



# NCLEX-PN<sup>®</sup> Prep 2019

**Our 80 years' expertise = Your competitive advantage**

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**Practice Test + Proven Strategies**

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The material in this book is current at the time of publication. However, the National Council of State Boards of Nursing may have instituted changes in the test after this book was published. Be sure to carefully read the materials you receive when you register for the test. If there are any important late-breaking developments—or any changes or corrections to the Kaplan test preparation materials in this book—we will post that information online at [kaptest.com/publishing](https://kaptest.com/publishing).

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# HOW TO USE THIS BOOK

## STEP 1: Sign Up for an Online Classroom Event

Log on to [kaptest.com/nclex](https://www.kaptest.com/nclex) to access a live classroom event led by one of Kaplan's NCLEX-PN® experts—free! See “Sign Up for an Online Classroom Event” in this book for more details and to register.

## STEP 2: Read and Complete Parts 1 and 2

The chapters in Parts 1 and 2 of this book contain a comprehensive, detailed strategy guide for each type of question on the NCLEX-PN® exam. This information will teach you how to analyze each question and use your nursing knowledge to select the correct answer choice. Plus, each chapter in Part 2 ends with practice questions and detailed answer explanations, designed to help you master NCLEX-PN® exam questions.

## STEP 3: Read Part 3

Part 3 will help you determine the most effective methods of exam preparation for you and will guide you in the licensure process.

Chapter 12, Essentials for International Nurses, contains information on certification for graduates of foreign nursing schools, work visas, and programs that can help you prepare for the NCLEX-PN® exam. This chapter also covers nursing practice in the United States and includes

practice questions with complete explanations designed to help you master NCLEX-PN® exam-type questions on the important subject of nursing communication.

#### STEP 4: Take the Practice Test

Use the test in this book, complete with in-depth answer explanations, to prepare for the real NCLEX-PN® exam. Take the test under timed conditions and then work through the explanations. Identify any areas of weakness, and use your remaining review time to address them, using the strategies outlined in this book. Note your strengths as well—these will help you on the test and can give you a sense of confidence.

#### STEP 5: Register for the Exam

When you are prepared to take the NCLEX-PN® exam, use the contact information provided in Appendix D, State Boards of Nursing, in Part 3 to initiate the registration process. All the steps you'll need to follow are contained in Chapter 10, The Licensure Process.

# SIGN UP FOR AN ONLINE CLASSROOM EVENT

Kaplan's NCLEX-PN® online classroom sessions are interactive, instructor-led NCLEX-PN® prep lessons that you can participate in from anywhere you can access the Internet.

The online sessions are held in a state-of-the-art virtual classroom—actual lessons in real time, just like an in-person classroom experience. Interact with your teacher and other classmates using audio, instant chat, whiteboard, polling, and screen-sharing functionality. And as in a Kaplan Nursing course held in person, an NCLEX-PN® online classroom session is led by an experienced Kaplan instructor.

To register for your NCLEX-PN® online classroom session:

Go to <http://www.kaptest.com/nursing/nclex-prep/> and click “Free Practice.” Then click "Upcoming NCLEX-PN(R) events" and scroll down to “NCLEX-PN” to see the dates and times of upcoming NCLEX-PN® Live Online classroom events.

Select a date for your Live Online classroom event by clicking "Sign Up." A new screen will appear with registration instructions. Follow the prompts to sign up.

Once you've signed up for the event, click on the link to your personalized “Student Homepage” to see your event schedule and any

associated online assets. You will receive a confirmation email recording the date and time of your event.

When it is time for your event to start, click into “My Account” and scroll down to “My Events,” then click “Attend Online.” A new screen will connect you to your Live Online classroom event.

Prior to attending the event, please check your computer settings by reviewing the system requirements and running the tech check. You may be prompted to install the Adobe Connect plug-in.

On the day of your free classroom event, sign in to your Student Homepage. You can enter Kaplan's virtual classroom up to 15 minutes before the scheduled start time.

Please note: Registration begins one month before the session date. Be sure to sign up early, since spaces are reserved on a first-come, first-served basis.



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## PART 1

# NCLEX-PN<sup>®</sup> EXAM OVERVIEW

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## CHAPTER 1

# OVERVIEW OF THE NCLEX-PN<sup>®</sup> EXAM

The NCLEX-PN<sup>®</sup> exam is, among other things, an endurance test, like a marathon. If you don't prepare properly, or approach it with confidence and rigor, you'll quickly lose your composure. Here is a sample, test-like question:

A client had a permanent pacemaker implanted one year ago. The client returns to the outpatient clinic for suspected pacemaker battery failure. It is **most** important for the LPN/LVN to assess which of the following?

1. Abdominal pain, nausea, and vomiting.
2. Wheezing on exertion, cyanosis, and orthopnea.
3. Palpitations, shortness of breath, and dizziness.
4. Chest pain, headache, and diaphoresis.

As you can see, the style and content of the NCLEX-PN<sup>®</sup> exam is unique. It's not like any other exam you've ever taken, even in nursing school!

The content in this book was prepared by the experts on Kaplan's Nursing team, the world's largest provider of test prep courses for the NCLEX-PN® exam. By using Kaplan's proven methods and strategies, you will be able to take control of the exam, just as you have taken control of your nursing education and other preparations for your career in this incredibly challenging and rewarding field. The first step is to learn everything you can about the exam.



# What Is the NCLEX-PN<sup>®</sup> Exam?

NCLEX-PN<sup>®</sup> stands for National Council Licensure Examination–Practical Nurse. The NCLEX-PN<sup>®</sup> examination is administered by the National Council of State Boards of Nursing (NCSBN), whose members include the boards of nursing in each of the 50 states in the United States, the District of Columbia, and four U.S. territories: American Samoa, Guam, the Northern Mariana Islands, and the Virgin Islands. These boards have a mandate to protect the public from unsafe and ineffective nursing care, and each board has been given responsibility to regulate the practice of nursing in its respective state. In fact, the NCLEX-PN<sup>®</sup> exam is often referred to as “the Boards” or “State Boards.”

The NCLEX-PN<sup>®</sup> exam has only one purpose: to determine if it is safe for you to begin practice as an entry-level practical/vocational nurse.

## Why Must You Take the NCLEX-PN<sup>®</sup> Exam?

The NCLEX-PN<sup>®</sup> exam is prepared by the NCSBN. Each state requires that you pass this exam to obtain a license to practice as a practical/vocational nurse. The designation licensed practical/vocational nurse or LPN/LVN indicates that you have proven to your state board of nursing or regulatory body that you can deliver safe and effective nursing care. The NCLEX-PN<sup>®</sup> exam is a test of minimum competency and is based on the knowledge and behaviors that are needed for the entry-level practice of

practical/vocational nursing. This exam tests not only your knowledge, but also your ability to make competent nursing decisions.

## What Is Entry-Level Practice of Practical/Vocational Nursing?

In order to define entry-level practice of practical/vocational nursing, NCSBN conducts a job-analysis study every three years to determine what entry-level nurses do on the job. The kinds of questions they investigate include: In which clinical settings does the beginning practical/vocational nurse work? What types of care do beginning practical/vocational nurses provide to their clients? What are their primary duties and responsibilities? Based on the results of this study, NCSBN adjusts the content and level of difficulty of the test to accurately reflect what is happening in the workplace.

## What the NCLEX-PN<sup>®</sup> Exam Is NOT

It is not a test of achievement or intelligence. It is not designed for nurses who have years of experience. The questions do not involve high-tech clinical nursing or equipment. It is not predictive of your eventual success in the career of nursing. You will not be tested on all the content that you were taught in practical/vocational nursing school.

## What Is a CAT?

CAT stands for Computer Adaptive Test. Each test is assembled interactively based on the accuracy of the candidate's response to the questions. This ensures that the questions you are answering are not “too hard” or “too easy” for your skill level. Your first question will be relatively easy; that is, below the level of minimum competency. If you answer that question correctly, the computer selects a slightly more difficult question. If you answer the first question incorrectly, the computer selects a slightly easier question (Figure 1). By continuing to do this as you answer questions, the computer is able to calculate your level of competence.

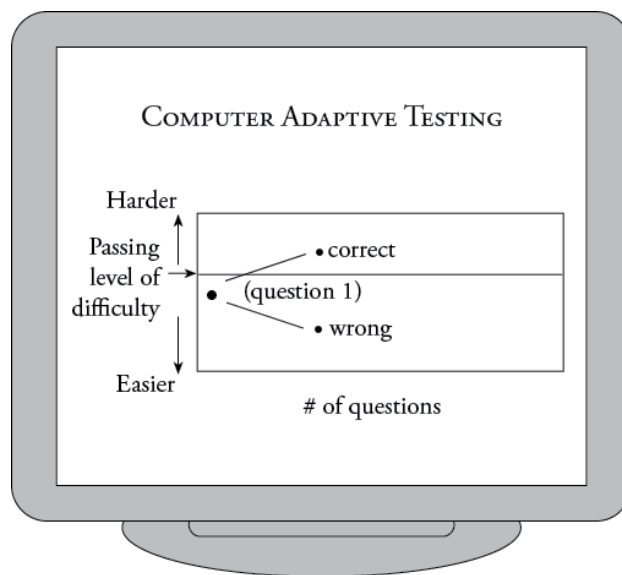


Figure 1

In a CAT, the questions are adapted to your level of ability. The computer selects questions that represent all areas of nursing, as defined by the NCLEX-PN<sup>®</sup> test plan and by the level of item difficulty. Each question is self-contained, so that all of the information you need to answer a question is presented on the computer screen.

## Taking the Exam

There is no time limit for each individual question. You have a maximum of five hours to complete the exam, but that includes the beginning tutorial, an optional 10-minute break after the first two hours of testing, and an optional break after an additional 90 minutes of testing. Everyone answers a minimum of 85 questions to a maximum of 205 questions. Regardless of the number of questions you answer, you are given 25 questions that are experimental. These questions, which are indistinguishable from the other questions on the test, are being tested for future use in NCLEX-PN<sup>®</sup> exams, and your answers do not count for or against you.

Your test ends when one of the following occurs:

- You have demonstrated minimum competency and answered the minimum number of questions (85) (Figure 2).
- You have demonstrated a lack of minimum competency and answered the minimum number of questions (85) (Figure 3).
- You have answered the maximum number of questions (205).
- You have used the maximum time allowed (five hours).

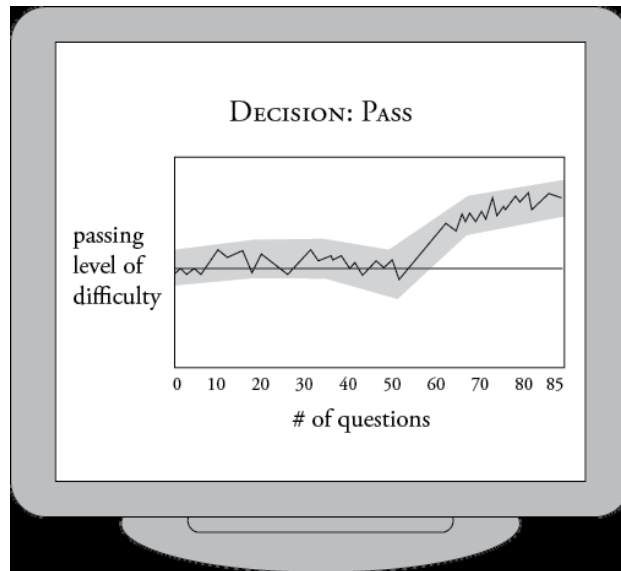


Figure 2

Try not to be concerned with the length of your test. In fact, you should plan on testing for five hours and seeing 205 questions. You are still in the game as long as the computer continues to give you test questions, so focus on answering them to the best of your ability.

Remember, every question counts. There is no warm-up time, so it is important for you to be ready to answer questions correctly from the very beginning. Concentration is also key. You need to give your best to each question because you do not know which one will put you over the top.



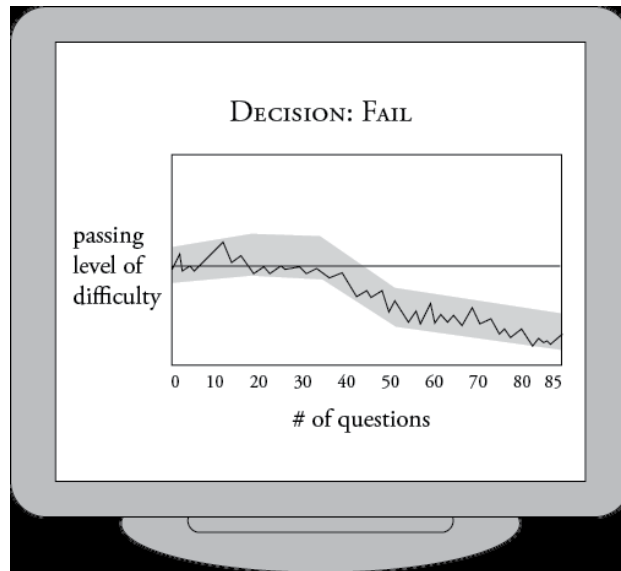


Figure 3

# Content of the NCLEX-PN<sup>®</sup> Exam

The NCLEX-PN<sup>®</sup> exam is not divided into separate content areas. It tests integrated nursing content. Many nursing programs are based on the medical model. Students take separate medical, surgical, pediatric, psychiatric, and obstetric classes. On the NCLEX-PN<sup>®</sup> exam, all content is integrated.

Look at the following question.

A client with type 1 diabetes returns to the recovery room one hour after an uneventful delivery of a 9 lb, 8 oz (4,309 g), newborn. The nurse would expect which of these changes in the client's blood glucose level?

1. From 220 to 180 mg/dL (12.21 to 10 mmol/L).
2. From 110 to 80 mg/dL (6.1 to 4.4 mmol/L).
3. From 90 to 120 mg/dL (5 to 6.7 mmol/L).
4. From 100 to 140 mg/dL (5.6 to 7.8 mmol/L).

Is this an obstetrical question or a medical/surgical question? In order to select the correct answer, (2), you must consider the

pathophysiology of diabetes along with the principles of labor and delivery. This is an example of an integrated question.

## The NCLEX-PN® Exam Blueprint

The NCLEX-PN® exam is organized according to the framework “Client Needs.” There are four major categories of client needs; two of the major categories are further divided for a total of six subcategories. This information is distributed by NCSBN, the developer of the NCLEX-PN® exam.

### Client Need #1: Safe and Effective Care Environment

The first subcategory for this client need is Coordinated Care, which accounts for 13–19 percent of the questions on the exam. Nursing actions that are covered in this subcategory include:

- Advance directives
- Advocacy
- Client care assignments
- Client rights
- Collaboration with interdisciplinary team
- Concepts of management and supervision
- Confidentiality/information security
- Continuity of care
- Establishing priorities
- Ethical practice
- Informed consent

- Information technology
- Legal responsibilities
- Performance improvement (quality improvement)
- Referral process
- Resource management

Here is an example of a typical question from the Coordinated Care subcategory:

The LPN/LVN knows that an assignment to which of the following clients would be appropriate?

1. A client with emphysema scheduled for discharge.
2. A client in traction for treatment of a fractured femur.
3. A client with low back pain scheduled for a myelogram.
4. A client newly diagnosed with type 1 diabetes.

The correct answer is (2). This client is in stable condition and can be cared for by an LPN/LVN.

Here is another example of a Coordinated Care question:

After receiving hand-off of care report from the RN, which of the following clients should the LPN/LVN see

**first?**

1. A client refusing to take sucralfate before mealtime.
2. A client with left-sided weakness asking for assistance to the commode.
3. A client reporting chills who is scheduled for a cholecystectomy.
4. A client with a nasogastric tube who had a bowel resection yesterday.

The correct answer is (3). This is the least stable client.

The second subcategory for this client need is Safety and Infection Control, which accounts for 11–17 percent of the questions on the exam. Nursing actions that are covered in this subcategory include:

- Accident/error/injury prevention
- Emergency response plan
- Ergonomic principles
- Handling hazardous and infectious materials
- Home safety
- Reporting of incident/event/irregular occurrence/variance
- Restraints and safety devices
- Safe use of equipment
- Security plan
- Standard precautions/transmission-based precautions/surgical asepsis

Here is an example of a question from the Safety and Infection Control subcategory:

The primary health care provider prescribes amoxicillin 150 mg PO in oral suspension every 8 hours for a 3-year-old client. The LPN/LVN enters the client's room to administer the medication and discovers that the client does not have an identification bracelet. Which of the following should the LPN/LVN take?

1. Ask the parents to state their child's name.
2. Ask the child to say the first and last name.
3. Have a coworker identify the child before giving the medication.
4. Hold the medication until an identification bracelet can be obtained.

The correct answer is (1). This action will allow the nurse to correctly identify the child and enable the nurse to give the medication on time.

## Client Need #2: Health Promotion and Maintenance

This client need accounts for 7–13 percent of the questions on the exam. Nursing actions that are covered in this category include:

- Aging process

- Ante/intra/postpartum and newborn care
- Data collection techniques
- Developmental stages and transitions
- Health promotion/disease prevention
- High-risk behaviors
- Lifestyle choices
- Self-care

It is important to understand that not everyone described in the questions will be sick, hospitalized, or in a long-term care facility. Some clients may be in a clinic or home-care setting. Some clients may not be sick at all. Wellness is an important concept on the NCLEX-PN<sup>®</sup> exam. It is necessary for a safe and effective practical/vocational nurse to know how to promote health and prevent disease.

The following is an example of a typical question from the Health Promotion and Maintenance category:

The LPN/LVN in the outpatient clinic notes that the blood pressure for a client is 190/100 mm Hg . The LPN/LVN should take which of the following actions?

1. Report the blood pressure reading to the RN.
2. Wait 20 minutes and retake the blood pressure.
3. Use a different cuff and retake the blood pressure.
4. Position the client supine with feet elevated.

The correct answer is (1). The LPN/LVN is responsible for data collection and should report findings that are abnormal to the supervising RN. Immediate action should be taken, so (2) is incorrect. It is unnecessary to recheck the blood pressure using other equipment (3) or to position the client supine with feet elevated (4).

## Client Need #3: Psychosocial Integrity

This client need accounts for 7–13 percent of the questions on the exam. Nursing actions that are covered in this category include:

- Abuse/neglect
- Behavioral management
- Chemical and other dependencies
- Coping mechanisms
- Crisis intervention
- Cultural awareness
- End-of-life concepts
- Grief and loss
- Mental health concepts
- Religious and spiritual influences on health
- Sensory/perceptual alterations
- Stress management
- Support systems
- Therapeutic communication
- Therapeutic environment



This is an example of a typical question from the Psychosocial Integrity category:

A client comes to the nurses' station and inquires about going to the cafeteria to get something to eat. The client becomes verbally abusive when told personal privileges do not include going to the cafeteria . Which of the following approaches by the LPN/LVN would be **most** effective?

1. Tell the client to speak softly to avoid disturbing the other clients.
2. Ask what the client wants from the cafeteria and have it delivered to the client's room.
3. Calmly but firmly escort the client back to the client's room.
4. Assign the unlicensed assistive personnel (UAP) to accompany the client to the cafeteria.

The correct answer is (3). The nurse should not reinforce abusive behavior. Clients need consistent and clearly defined expectations and limits.

## Client Need #4: Physiological Integrity

The first subcategory for this client need is Basic Care and Comfort, which accounts for 9–15 percent of the questions on the exam. Nursing actions

that are covered in this subcategory include:

- Assistive devices
- Elimination
- Mobility/immobility
- Non-pharmacological comfort interventions
- Nutrition and oral hydration
- Personal hygiene
- Rest and sleep

The following question is representative of the Basic Care and Comfort subcategory:

The primary health care provider is applying a cast to an infant for treatment of talipes equinovarus. Which of the following instructions is **most** essential for the LPN/LVN to give to the child's parents regarding care?

1. Offer age-appropriate toys.
2. Visit clinic frequently for cast adjustments.
3. Give an analgesic as needed.
4. Check circulation in the casted extremity.

The correct answer is (4). A possible complication that can occur after cast application is impaired circulation. All of these answer choices might be included in family teaching, but checking the child's circulation is the highest priority.

The second subcategory for this client need is Pharmacological Therapies, which makes up for 11–17 percent of the questions on the exam. Nursing actions that are covered in this subcategory include:

- Adverse effects/contraindications/side effects/interactions
- Dosage calculations
- Expected actions/outcomes
- Medication administration
- Pharmacological pain management

Because the brand name or trade name of drugs may vary, you should expect to see the use of generic medication names only on the NCLEX-PN® exam.

Try this question from the Pharmacological Therapies subcategory:

The LPN/LVN notes the client is allergic to an ordered medication. Which of the following is the correct action by the LPN/LVN?

1. Administer the medication as the primary health care provider ordered it.
2. Administer the medication and closely observe the client.
3. Call the pharmacist to verify potential allergic responses.
4. Call the primary health care provider and report the medication allergy.

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The correct answer is (4). The LPN/LVN must notify the primary health care provider regarding the client's allergy to revise the medication order.

The third subcategory for this client need is Reduction of Risk Potential, which accounts for 9–15 percent of the questions on the exam. Nursing actions that are covered in this subcategory include:

- Changes/abnormalities in vital signs
- Diagnostic tests
- Laboratory values
- Potential for alterations in body systems
- Potential for complications of diagnostic tests/treatments/procedures
- Potential for complications from surgical procedures and health alterations
- Therapeutic procedures

This is an example of a question from the Reduction of Risk Potential subcategory:

Parents bring a school-age client with a history of type 1 diabetes and several days of illness to the emergency department (ED). Which of the following laboratory test results would the LPN/LVN expect if the client is experiencing diabetic ketoacidosis?

1. Serum glucose 140 mg/dL (7.8 mmol/L).
2. Serum creatine 5.2 mg/dL (460  $\mu$ mol/L).
3. Blood pH 7.28.
4. Hematocrit 38%.

The correct answer is (3). Normal blood pH is 7.35–7.45. A blood pH of 7.28 indicates diabetic ketoacidosis.

The fourth subcategory for this client need is Physiological Adaptation, which accounts for 9–15 percent of the questions on the exam. Nursing actions that are covered in this subcategory include:

- Alterations in body systems
- Basic pathophysiology
- Fluid and electrolyte imbalances
- Medical emergencies
- Radiation therapy
- Unexpected response to therapies

The following is an example of a Physiological Adaptation question:

The LPN/LVN is delivering external cardiac compressions to a client during cardiopulmonary resuscitation (CPR). Which of the following actions by the LPN/LVN is **best**?

1. Maintain a position close to the client's side with the nurse's knees apart.
2. Position hands on the lower half of the sternum during compressions.
3. Lean on chest between compressions to prevent full chest wall recoil.
4. Check for a return of the client's pulse after every 8 breaths by the nurse.

The correct answer is (2). The nurse's hands should be positioned on the lower half of the client's sternum during compressions with elbows locked, arms straight, and shoulders positioned directly over the hands. The nurse should avoid leaning on the chest between compressions to allow for full chest wall recoil.

## The Nursing Process

Several processes are integrated throughout the NCLEX-PN® exam. The most important of these is the nursing process.

For the practical/vocational nurse, the nursing process involves data collection, planning, implementation, and evaluation of nursing care. You will help the registered nurse, or other qualified health professional, formulate a plan of nursing care for clients in a variety of settings. As a graduate practical/vocational nurse, you are very familiar with each step of the nursing process and how to assist in writing a care plan using this process. Knowledge of the nursing process is essential to the performance

of safe and effective care. It is also essential to answering questions correctly on the NCLEX-PN® exam.

Now we are going to review the steps of the nursing process and show you how each step is incorporated into test questions. The nursing process is a way of thinking. Using it will help you select correct answers.

**Data collection.** Data collection is the process of establishing and verifying a database of information about the client. This permits you to collaborate in the identification of actual and/or potential health problems. The practical/vocational nurse obtains subjective data (information given to you by the client that can't be observed or measured by others) and objective data (information that is observable and measurable by others). This data is collected by interviewing and observing the client and/or significant others, reviewing the health history, performing a physical assessment, gathering lab results, and interacting with the registered nurse and members of the health care team.

An example of a data collection test question is:

The LPN/LVN is obtaining a health history from a client admitted with acute glomerulonephritis. Which of the following history finding is significant for the diagnosis of acute glomerulonephritis?

1. Personal history of sore throat 10 days ago.
2. Family history of chronic glomerulonephritis.
3. Personal history of renal calculus 2 years ago.
4. Personal history of renal trauma several years ago.

The correct answer is (1). Acute glomerulonephritis, an immunologic disorder that affects the kidneys, can be caused by group A Streptococcus. It usually occurs about 10 days after strep throat or scarlet fever and about 21 days after a group A Streptococcus skin infection.

Planning. During the planning phase of the nursing process, the nursing care plan is formulated collaboratively with the registered nurse. Steps in planning include:

- Assigning priorities to nursing diagnosis
- Specifying goals
- Identifying interventions
- Specifying expected outcomes
- Documenting the nursing care plan

Goals are anticipated responses and client behaviors that result from nursing care. Nursing goals are client-centered and measurable, and they have an established time frame. Expected outcomes are the interim steps needed to reach a goal and the resolution of a nursing diagnosis. There will be multiple expected outcomes for each goal. Expected outcomes guide the practical/vocational nurse in planning interventions.



This is an example of a planning question:

A client reporting nausea, vomiting, and severe right upper quadrant pain is admitted to the medical/surgical unit. The client's temperature is 101.3° F (38.5° C) and an abdominal x-ray reveals an enlarged gallbladder. The client is scheduled for surgery. Which of the following actions should the LPN/LVN take **first**?

1. Assess the client's need for dietary teaching.
2. Evaluate the client's fluid and electrolyte status.
3. Examine the client's health history for allergies to antibiotics.
4. Determine whether the client has signed consent for surgery.

The correct answer is (2). Hypokalemia and hypomagnesemia commonly occur after repeated vomiting.

Implementation. Implementation is the term used to describe the actions that you take in the care of your clients. Implementation includes:

- Assisting in the performance of activities of daily living (ADL)
- Implementing the educational plan for the client and family
- Giving care to clients

It is important for you to remember that nursing interventions may be:

- Independent actions that do not require supervision by others. These nursing interventions are usually not within the scope of practice for practical/vocational nurses. However, the LPN/LVN can follow established care plans, standards of care, and established protocols.
- Dependent actions based on the written orders of a physician.
- Interdependent actions shared with the registered nurse or other members of the health team.

The NCLEX-PN® exam includes questions that involve all three types of nursing interventions.

Here is an example of an implementation question:

A client is being treated in the burn unit for second- and third-degree burns over 45% of his body. The primary health care provider prescribes silver sulfadiazine cream application. Which method is **best** for the LPN/LVN to apply this medication?

1. Sterile dressings soaked in saline.
2. Sterile tongue depressor.
3. Sterile gloved hand.
4. Sterile cotton-tipped applicator.

The correct answer is (3). A sterile, gloved hand will cause the least trauma to tissues and will decrease the chances of breaking blisters.

Evaluation. Evaluation measures the client's response to nursing interventions and indicates the client's progress toward achieving the goals established in the care plan. You compare the observed results with expected outcomes in collaboration with the registered nurse.

This is an evaluation question:

When caring for a client diagnosed with anorexia nervosa, which of the following observations indicates to the LPN/LVN that the client's condition is improving?

1. The client eats all food on the meal tray.
2. The client asks friends to bring special foods.
3. The client weighs self daily.
4. The client has gained weight.

The correct response is (4). The client's weight is the most objective outcome measure in the evaluation of this client's problem.

## Integrated Processes

Several other important processes are integrated throughout the NCLEX-PN® exam. They are:

Caring. As you take the NCLEX-PN® exam, remember that the test is about caring for people, not working with high-tech equipment or analyzing lab

results.

**Communication and Documentation.** For this exam, you are required to understand and utilize therapeutic communication skills with all professional contacts, including clients, their families, and other members of the health care team. Charting or documenting your care and the client's response is both a legal requirement and an essential method of communication in nursing. On this exam you may be asked to identify appropriate documentation of a client behavior or nursing action.

**Teaching/Learning Principles.** Nursing frequently involves sharing information with clients and families so optimal functioning can be achieved. You may see questions concerning teaching a client about his or her diet and/or medications.

You might see some questions on the NCLEX-PN® exam that contain graphics (pictures). These questions may include the picture of a client in traction or a pregnant woman's abdomen. These questions do count, so take them seriously. We have included several questions with graphics in the practice test found in this book.

## Knowledge Is Power

The more knowledgeable you are about the NCLEX-PN® exam, the more effective your study will be. As you prepare for the exam, keep the content of the test in mind. Thinking like the test maker will enhance your chance of success on the exam.

Are you still thinking about the question involving the pacemaker battery on page 3? What do you think the correct answer is?

A client had a permanent pacemaker implanted one year ago. The client returns to the outpatient clinic for suspected pacemaker battery failure. It is **most** important for the LPN/LVN to assess for which of the following?

1. Abdominal pain, nausea, and vomiting.
2. Wheezing on exertion, cyanosis, and orthopnea.
3. Palpitations, shortness of breath, and dizziness.
4. Chest pain, headache, and diaphoresis.

The correct answer is (3). Palpitations, shortness of breath, dizziness, lightheadedness, syncope, irregular heart rate, and tachycardia or bradycardia may occur with pacemaker battery failure.

Gastrointestinal symptoms (1) are not found with pacemaker malfunction. The items listed in (2) are not symptoms of pacemaker failure. And although chest pain may occur with decreased output (4), chest pain is suggestive of angina. Headache and diaphoresis are not seen with pacemaker failure.



## CHAPTER 2

# GENERAL TEST STRATEGIES

As a nursing student, you are used to taking multiple-choice tests. In fact, you've taken so many tests by the time you graduate from nursing school, you probably believe that there won't be any more surprises on any nursing test, including the NCLEX-PN® exam.

But if you've ever talked to graduate practical/vocational nurses about their experiences taking the NCLEX-PN® exam, they probably told you that the test wasn't like any nursing test they had ever taken. How can that be? How can the NCLEX-PN® exam seem like a practical/vocational nursing school test but be so different? The reason is that the NCLEX-PN® exam is a standardized test that analyzes a different set of behaviors from those tested in nursing school.

# Standardized Exams

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Many of you have some experience with standardized exams. You may have been required to take the SAT or ACT to get into nursing school. Remember taking that exam? Was your experience positive or negative?

All standardized exams share the same characteristics:

- Tests are written by content specialists and test-construction experts.
- The content of the exam is researched and planned.
- The questions are designed according to test construction methodology (all answer choices are about the same length, the verb tenses all agree, etc.).
- All the questions are tested before use on the actual exam.

The NCLEX-PN® exam is similar to other standardized exams in some ways yet different in others:

- The NCLEX-PN® exam is written by nurse specialists who are experts in a content area of nursing.
- All content is selected to allow the beginning practical/vocational nurse to prove minimum competency on all areas of the test plan.
- Minimum-competency questions are most frequently asked at the application level, not the recognition or recall level. All the responses to

a question are similar in length and subject matter, and are grammatically correct.

- All test items have been extensively tested by NCSBN. The questions are valid; all correct responses are documented in two different sources.

What does this mean for you?

- NCSBN has defined what is minimum-competency, entry-level nursing.
- Questions and answers will be written in such a way that you cannot, in most cases, predict or recognize the correct answer.
- NCSBN is knowledgeable about strategies regarding length of answers, grammar, and so on. It makes sure that you can't use these strategies in order to select correct answers. English majors have no advantage!
- The answer choices have been extensively tested. The people who write the test questions make the incorrect answer choices look attractive to the unwary test taker.





# What Behaviors Does the NCLEX-PN<sup>®</sup> Exam Test?

The NCLEX-PN<sup>®</sup> exam does not just test your nursing knowledge: It assumes that you have a body of knowledge and you understand the material because you have graduated from nursing school. So what does the NCLEX-PN<sup>®</sup> exam test? The NCLEX-PN<sup>®</sup> exam primarily tests your nursing decisions. It tests your ability to think critically and solve problems.

## Critical Thinking

What does the term critical thinking mean? Critical thinking is problem solving that involves thinking creatively. It requires that the practical/vocational nurse:

- Observe.
- Decide what is important.
- Look for patterns and relationships.
- Identify normal and abnormal.
- Identify the problem.
- Transfer knowledge from one situation to another.
- Apply knowledge.
- Evaluate according to criteria established.

You successfully solve problems every day in the clinical area. You are probably comfortable with this concept when actually caring for clients. Although you've had lots of practice critically thinking in the clinical area, you may have had less practice critically thinking your way through test questions. Why is that?

During nursing school, you take exams developed by nursing instructors to test a specific body of content. Many of these questions are at the knowledge level. This involves recognition and recall of ideas or material that you read in your nursing textbooks and discussed in class. This is the most basic level of testing. Figure 1 illustrates the different levels of questions on nursing exams.

The following is an example of a knowledge-based question you might have seen in nursing school.

**Which of the following is a complication that occurs during the first 24 hours after a percutaneous liver biopsy?**

1.           **Nausea and vomiting.**
2.           **Constipation.**
3.           **Hemorrhage.**
4.           **Pain at the biopsy site.**

The question restated is, "What is a common complication of a liver biopsy?" You may or may not remember the answer. So, as you look at the answer choices, you hope to see an item that looks familiar. You do see something that looks familiar: "Hemorrhage." You select the correct

answer based on recall or recognition. The NCLEX-PN® exam rarely asks passing questions at the recall/recognition level.

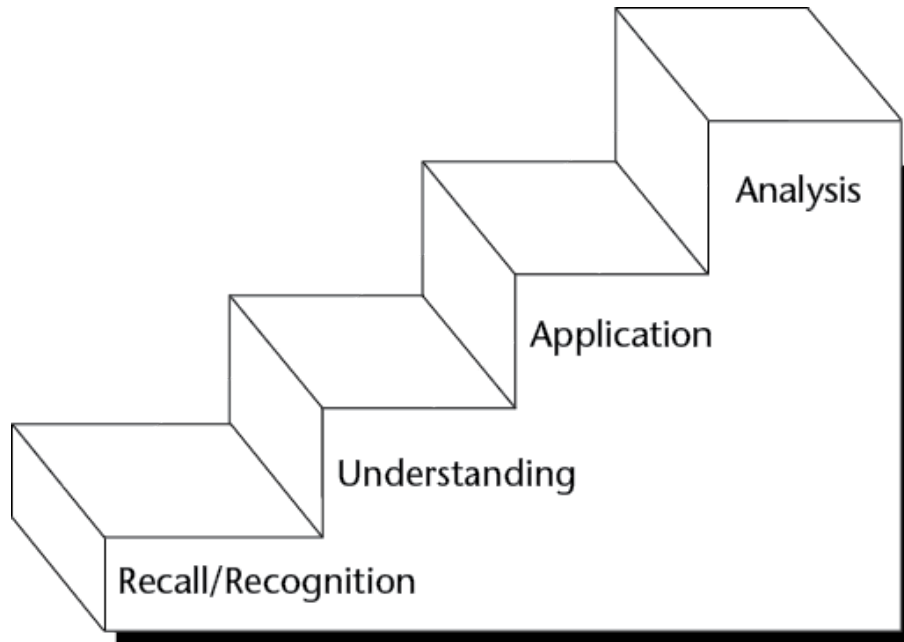


Figure 1: Levels of Questions in Nursing Tests

In nursing school, you are also given test questions written at the comprehension level. These questions require you to understand the meaning of the material. Let's look at this same question written at the comprehension level.

**The LPN/LVN understands that hemorrhage is a complication of a liver biopsy due to which of the following reasons?**

- )           **There are several large blood vessels near the liver.**
- ;)           **The liver cells are bathed with a mixture of venous and arterial blood.**

- ) **The test is performed on clients with elevated enzymes.**
- ) **The procedure requires a large piece of tissue to be removed.**

The question restated is, “Why does hemorrhage occur after a liver biopsy?” In order to answer this question, the nurse must understand that the liver is a highly vascular organ. The portal vein and the hepatic artery join in the liver to form the sinusoids that bathe the liver in a mixture of venous and arterial blood.

The NCLEX-PN® exam asks few minimum-competency questions at the comprehension level. It assumes you know and understand the facts you learned in practical/vocational nursing school.

Minimum-competency NCLEX-PN® exam questions are written at the application and/or analysis level. Remember, the NCLEX-PN® exam tests your ability to make safe judgments about client care. Your ability to solve problems is not tested with questions at the recall/recognition or comprehension level.

Let’s look at this same question written at the application level.

Which of the following symptoms observed by the LPN/LVN during the first 24 hours after a percutaneous liver biopsy would indicate a complication from the procedure?

1. Anorexia, nausea, and vomiting.
2. Abdominal distention and discomfort.
3. Pulse 112 beats/minute and blood pressure 86/60 mm Hg.
4. Redness and pain at the biopsy site.

Can you select an answer based on recall or recognition? No. Let's analyze the question and answer choices.

The question is: What is a complication of a liver biopsy? In order to begin to analyze this question, you must know that hemorrhage is the major complication. However, it's not listed as an answer. Can you find hemorrhage in one of the answer choices?

#### ANSWERS:

Anorexia, nausea, and vomiting. Does this indicate that the client is hemorrhaging? No, these are not symptoms of hemorrhage.

Abdominal distention and discomfort. Does this indicate that the client is hemorrhaging? Perhaps. Abdominal distention could indicate internal bleeding.

"Pulse 112 beats/minute and blood pressure 86/60 mm Hg." Does this indicate that the client is hemorrhaging? Yes. An increased pulse and a decreased blood pressure indicate shock. Shock is a result of hemorrhage.

"Redness and pain at the biopsy site." Does this indicate the client is hemorrhaging? No. Pain and some redness at the biopsy site may occur as a normal result of the procedure.

Ask yourself, “Which is the best indicator of hemorrhage?” Abdominal distention or a change in vital signs? Abdominal distention can be caused by liver disease. The correct answer is (3).

This question tests you at the application level. You were not able to answer the question by recalling or recognizing the word hemorrhage. You had to take information you learned (hemorrhage is the major complication of a liver biopsy) and select the answer that best indicates hemorrhage. Application involves taking the facts that you know and using them to make a nursing judgment. You must be able to answer questions at the application level in order to prove your competence on the NCLEX-PN® exam.

Let’s look at a question that is written at the analysis level.

The LPN/LVN is caring for a client receiving haloperidol 2 mg PO bid. The LPN/LVN assists the client to choose which of the following menus?

1. 6 oz (168 g) roast beef, baked potato, salad with dressing, dill pickle, baked apple pie, and milk.
2. 3 oz (84 g) baked chicken, green beans, steamed rice, 1 slice of bread, banana, and milk.
3. 6 oz (168 g) burger on a bun, french fries, apple, chocolate chip cookie, and milk to drink 30 minutes after mealtime.
4. 3 oz (84 g) baked fish, slice of bread, broccoli, ice cream, and pineapple juice to drink 60 minutes after mealtime.

Many students panic when they read this question because they can't immediately recall any diet restriction required by a client taking haloperidol. Because students can't recall the information, they assume that they didn't learn enough information. Analysis questions are often written so that a familiar piece of information is put in an unfamiliar setting. Let's think about this question.

What type of diet do you choose for a client receiving haloperidol? In order to begin analyzing this question, you must first recall that haloperidol is an antipsychotic medication used to treat psychotic disorders. There are no diet restrictions for clients taking haloperidol. Because there are no diet restrictions, you must problem-solve to determine what this question is really asking. Based on the answer choices, it is obviously a diet question. What kind of diet should you choose for this client? Because you have been given no other information, there is only one type of diet that can be considered: a regular balanced diet. This is an example of taking the familiar (a regular balanced diet) and putting it into the unfamiliar (a client

receiving haloperidol). In this question, the critical thinking is deciding what this question is really asking.

QUESTION: “What is the most balanced regular diet?”

ANSWERS:

“6 oz (168 g) roast beef, baked potato, salad with dressing, dill pickle, baked apple pie, and milk.” Is this a balanced diet? Yes, it certainly has possibilities.

“3 oz (84 g) baked chicken, green beans, steamed rice, 1 slice of bread, banana, and milk.” Is this a balanced diet? Yes, this is also a good answer because it contains foods from each of the food groups.

“6 oz (168 g) burger on a bun, french fries, apple, chocolate chip cookie, and milk to drink 30 minutes after mealtime.” Is this a balanced diet? No. This diet is high in fat and does not contain all of the food groups. Eliminate this answer.

“3 oz (84 g) baked fish, slice of bread, broccoli, ice cream, and pineapple juice to drink 60 minutes after mealtime.” Does this sound like a balanced diet? The choice of foods isn’t bad, but why would the intake of fluids be delayed? This sounds like a menu to prevent dumping syndrome. Eliminate this answer.

Which is the better answer choice: (1) or (2)? Dill pickles are high in sodium, so the correct answer is (2).

Choosing the menu that best represents a balanced diet is not a difficult question to answer. The challenge lies in determining that a balanced diet is the topic of the question. Note that answer choices (1) and (2) are very



similar. Because the NCLEX-PN® exam is testing your discretion, you will be making decisions between answer choices that are very close in meaning. Don't expect obvious answer choices.

These questions highlight the difference between the knowledge/comprehension-based questions that you may have seen in nursing school, and the application/analysis-based questions that you will see on the NCLEX-PN® exam.

# Strategies That Don't Work on the NCLEX-PN® Exam

Whether you realize it or not, you developed a set of strategies in nursing school to answer teacher-generated test questions that are written at the knowledge/comprehension level. These strategies include:

- “Cramming” in hundreds of facts about disease processes and nursing care
- Recognizing and recalling facts rather than understanding the pathophysiology and the needs of a client with an illness
- Knowing who wrote the question and what is important to that instructor
- Predicting answers based on what you remember or who wrote the test question
- Selecting the response that is a different length compared to the other choices
- Selecting the answer choice that is grammatically correct
- When in doubt, choosing answer choice (C)

These strategies will not work on the NCLEX-PN® exam. Remember, the NCLEX-PN® exam is testing your ability to make safe, competent decisions.



# Becoming a Better Test Taker

The first step to becoming a better test taker is to assess and identify the following:

- The kind of test taker you are
- The kind of learner you are

## Successful NCLEX-PN<sup>®</sup> Exam Test Takers

- Have a good understanding of nursing content.
- Have the ability to tackle each test question with a lot of confidence because they assume that they can figure out the right answer.
- Don't give up if they are unsure of the answer. They are not afraid to think about the question, and the possible choices, in order to select the correct answer.
- Possess the know-how to correctly identify the question.
- Stay focused on the question.

## Unsuccessful NCLEX-PN<sup>®</sup> Exam Test Takers

- Assume that they either know or don't know the answer to the question.
- Memorize facts to answer questions by recall or recognition.

- Read the question, read the answers, re-read the question, and pick an answer.
- Choose answer choices based on a hunch or a feeling instead of thinking carefully.
- Answer questions based on personal experience rather than nursing theory.
- Give up too soon, because they aren't willing to think hard about questions and answers.
- Don't stay focused on the question.

If you are a successful test taker, congratulations! This book will reinforce your test taking skills. If you have many of the characteristics of an unsuccessful test taker, don't despair! You can change. If you follow the strategies in this book, you will become a successful test taker.

## What Kind of Learner Are You?

It is important for you to identify whether you think predominantly in images or words. Why? This will assist you in developing a study plan that is specific for your learning style. Read the following statement:

A nurse walks into a room and finds the client lying on the floor.

As you read those words, did you hear yourself reading the words? Or did you see a nurse walking into a room, and see the client lying on the floor? If you heard yourself reading the sentence, you think in words. If you formed a mental image (saw a picture), you think in images.

Students who think in images sometimes have a difficult time answering nursing test questions. These students say things like:

“I have to study harder than the other students.”

“I have to look up the same information over and over again.”

“Once I see the procedure (or client), I don’t have any difficulty understanding or remembering the content.”

“I have trouble understanding procedures from reading the book. I have to see the procedure to understand it.”

“I have trouble answering test questions about clients or procedures I’ve never seen.”

Why is that? For some people, imagery is necessary to understand ideas and concepts. If this is true for you, you need to visualize information that you are learning. As you prepare for the NCLEX-PN® exam, try to form mental images of terminology, procedures, and diseases. For example, if you’re reviewing information about traction but you have never seen traction, it would be ideal for you to see a client in traction. If that isn’t possible, find a picture of traction and rig up a traction setup with whatever material you have available. As you read about traction, use the photo or model to visualize care of the client. If you can visualize the theory that you are trying to learn, it will make recall and understanding of concepts much easier for you.

It is also important that you visualize test questions. As you read the question and possible answer choices, picture yourself going through each suggested action. This will increase your chances of selecting correct answer choices.

Let's look at a test question that requires imagery.

An adolescent is brought to the emergency department (ED) for left femur fracture sustained in a sledding accident. The primary health care provider reduces the fracture and applies a cast. The client is taught how to use crutches for ambulating without bearing weight on the left leg. The LPN/LVN would expect the client to learn which of the following crutch-walking gaits?

1. Two-point gait.
2. Three-point gait.
3. Four-point gait.
4. Swing-through gait.

Don't panic if you can't remember crutch-walking gaits. Instead, visualize!

Step 1. "See" a person (or yourself ) walking normally. First the right leg and left arm are extended, and then the left leg and right arm are extended.

Step 2. Put crutches in your hands. Now walk. Each foot and each crutch is a point.

Step 3. "See" a person (or yourself ) with a full cast on the left leg, with the foot never touching the ground.

Step 4. Visualize the answers.

Two-point gait. One leg and one crutch would be touching the ground at the same time. Sounds like normal walking. Eliminate this choice because the client is non-weight-bearing.

Three-point gait. Both crutches and one foot are on the ground. This would be appropriate for a non-weight-bearing client.

Four-point gait. This would require both legs and crutches to touch the ground. However, in this question the client is non-weight-bearing. Eliminate this option.

Swing-through gait. This gait means advancing both crutches, then both legs, and requires weight-bearing. The gait is not as stable as the other gaits. Eliminate this option: the client in this question is non-weight-bearing.

The correct answer is (2).

Even if you are unsure of crutch walking gaits, imagining and thinking through the answer choices will enable you to select the correct answer.

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PART 2

NCLEX-PN<sup>®</sup> STRATEGIES AND  
PRACTICE

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## CHAPTER 3

# COMPUTER ADAPTIVE TEST STRATEGIES

The NCLEX-PN<sup>®</sup> exam is composed primarily of multiple-choice, four-option, text-based questions written at the application/analysis level of difficulty. These questions may include charts, tables, or graphic images.

Your NCLEX-PN<sup>®</sup> exam may also contain questions in a format other than traditional four-option, text-based, multiple-choice questions. These other types of questions, called alternate format questions, are part of the test pool of questions for the NCLEX-PN<sup>®</sup> exam. These alternate format question types include:

- Multiple-response questions that require you to select all answer choices that apply from among five or six answer options
- “Hot spot” questions that require you to identify a “hot spot” or specific area on a graphic image by clicking on the correct area with the mouse
- Fill-in-the-blank questions that require you to type in a number that you calculate into a blank space provided after the question
- Drag-and-drop/ordered response questions that ask you to place answers in a specific order

There are also three types of alternate format questions that are variations on the traditional four-option, multiple-choice question. These include:

- Chart/exhibit questions that require you to click an Exhibit button to display charts and/or exhibits that provide information needed to answer the question. Once you have done so, you then select the correct choice from four multiple-choice answer options.
- Audio questions that present you with an audio clip that you listen to on headphones. After listening to the clip, you then select the correct choice from among four multiple-choice answer options.
- Graphics questions that present you with graphics instead of text as the four multiple-choice answer options.

Questions either are counted toward your NCLEX-PN<sup>®</sup> exam results or they are experimental questions for future exams that are not counted.

This book contains strategies that help you correctly answer both alternate format questions and traditional four-option, text-based, multiple-choice questions.

# Alternate Format Test Questions

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Let's take a look at the individual alternate format question types and the strategies that help you correctly answer these questions.

## Select All That Apply—Click on all appropriate answer choices

Take a look at the following question:

The LPN/LVN is caring for a client diagnosed with a right-sided stroke with dysphagia. Which of the following actions by the LPN/LVN reflects appropriate care for the client? **Select all that apply.**

1. ☐ The LPN/LVN assesses the client's ability to swallow.
2. ☐ The LPN/LVN positions the client with the head of bed elevated 25 degrees.
3. ☐ The LPN/LVN offers the client scrambled eggs.
4. ☐ The LPN/LVN instructs the client to place food on the left side of the mouth.
5. ☐ The LPN/LVN turns off the television.

You will know that the question is a “Select all that apply” alternate format question because after the question stem and before the answer choices you are instructed to “Select all that apply.” You will note that there are more than four possible answer choices; usually five or six are provided. Also, there is a box in front of each answer choice rather than the radio button you see with multiple-choice, four-option, text-based questions.

To answer this type of question, determine which of the answer choices provided are correct. It is important to remember that in order for the question to be scored as correct you must select all of the correct responses that apply, not just the best response. You will not receive any partial credit if you do not. Left-click on the box in front of each answer choice that you think is correct. A small check mark appears in the box indicating that you selected that answer. If you change your mind about a particular answer choice, just click on the box again: the check mark disappears and the answer choice is no longer selected.

How should you approach this type of question? What doesn't work is to compare and contrast the individual answer choices. For a “Select all that

apply” question, any number of answer choices may be correct. Instead, consider each answer choice a True/False question. Rephrase this question to ask, “What is appropriate care for a client with a right-sided stroke who has dysphagia?” Dysphagia means the client is having difficulty swallowing; if the stroke is in the right hemisphere, the client’s left side is affected.

Let’s look at the answers. The strategy is to change each answer choice into a statement, and then determine whether the statement is true or false.

“I should assess the client’s ability to swallow.” Is this true for a client with dysphagia? Yes. This is a correct response because the nurse needs to make sure that the client can swallow food before giving him anything to eat. The results of the evaluation will also determine whether the nurse should offer the client clear liquids or thickened liquids. Some clients will require thickened liquids while others will not. Select this answer choice.

“I should position the client with the head of bed elevated 25 degrees.” Is this the correct position for a client with dysphagia? No. The client should be sitting upright in a chair or with the head of the bed elevated to at least 30 degrees. Eliminate this answer choice.

“I should offer the client scrambled eggs.” Is this an appropriate food for a client with dysphagia? Yes. Soft or semi-soft foods are more easily tolerated than a regular diet. Select this answer choice.

“I should instruct the client to place food on the left side of the mouth.” Is this what should be done? If the client has a right-sided stroke, that means the left side of the client’s body is affected. The food should be placed on the unaffected side—the right side of the mouth for this client. Eliminate this answer.

“I should turn off the television.” What are they getting at with this statement? Many clients are easily distracted after a stroke. If the client has dysphagia, you don’t want him to aspirate while being distracted by the television. It is best to turn off the TV during meals. Select this answer choice.

So, which answers should be checked as correct? For this question, choices (1), (3), and (5) are correct. Left-click on the box in front of each of these answer choices to select them. When you have selected all the responses you believe to be correct, click on the NEXT (N) button in the bottom left of the screen or press the Enter key on the keyboard to lock in your answer and go on to the next question. Remember, once you click on the NEXT (N) button or press the Enter key, you have entered your answer to the question and you cannot return to the question.

The LPN/LVN is caring for a client diagnosed with a right-sided stroke with dysphagia. Which of the following actions by the LPN/LVN reflects appropriate care for the client? **Select all that apply.**

1. ☒ The LPN/LVN assesses the client’s ability to swallow.
2. ☐ The LPN/LVN positions the client with the head of bed elevated 25 degrees.
3. ☒ The LPN/LVN offers the client scrambled eggs.
4. ☐ The LPN/LVN instructs the client to place food on the left side of the mouth.
5. ☒ The LPN/LVN turns off the client's television.

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## Hot Spot—Select the correct area and click the mouse

This type of alternate format question asks you to identify a location on a graphic or table. It is important to understand that this is not a test of your fine motor skills but is designed to evaluate your knowledge of nursing content, anatomy, physiology, and pathophysiology.

Let's take a look at a question that involves a hot spot.

The LPN/LVN is palpating peripheral pulses on an adult client. Identify the appropriate area in which the LPN/LVN would expect to palpate a client's dorsalis pedis pulse.

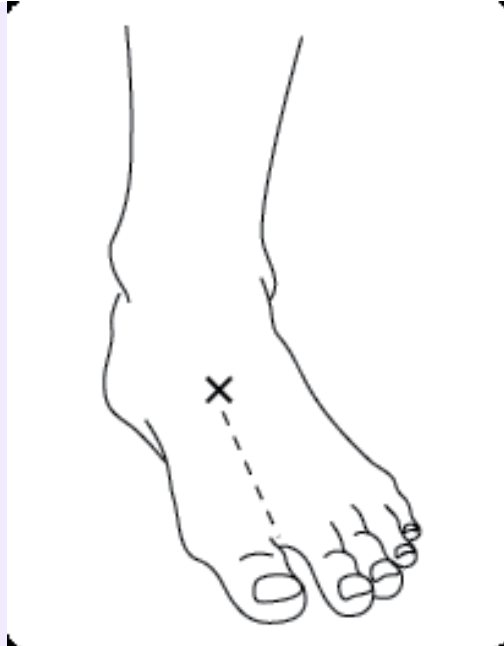


The question asks you to identify where you would palpate one of the two commonly assessed peripheral pulses found in the foot. The strategy you should use is to locate anatomical landmarks. You need to know that the dorsalis pedis pulse is located on the top (dorsum) of the client's foot. It is found between the first and second metatarsal bones (between the great and first toes) over the dorsalis pedis artery.

Using the computer's mouse, move the cursor to the location you think is correct. Then, left-click the mouse. Check to make sure that you have selected the location you wanted. Then enter your answer by clicking on the NEXT (N) button or pressing the Enter key. If you click between the second and third toes, for example, the location would be inaccurate for the dorsalis pedis pulse and the question would be counted wrong. Just do your best and use the anatomical landmarks to get your bearings and select the location.

The LPN/LVN is palpating peripheral pulses on an adult client. Identify the appropriate area in which the LPN/LVN would expect to palpate a client's dorsalis pedis pulse.





## Fill in the Blank—Enter the answer

This type of alternate format question asks you to fill in the blank with a number based on a calculation.

The following is a sample of a fill-in-the-blank question that is a calculation.

The LPN/LVN is caring for a client who has a primary health care provider order for strict intake and output. The client drinks 12 oz of lemon-lime soda and  $\frac{1}{2}$  cup grape juice between breakfast and lunch, and voids 200 mL of urine. Calculate and record the client's oral intake in milliliters for this period.

\_\_\_\_\_ mL

To answer this question, calculate the client's intake from the information provided. Note: Pay close attention to the unit of measure you need for your final answer. In this situation, you are asked for the client's intake in milliliters, not cups or ounces.

You can use the drop-down calculator provided on the computer to do the math. The button that displays the calculator is on the bottom of the right side of the computer screen. Use your mouse to click on the numbers or functions you want. Remember, the slash (/) is used for division.

First, convert cups into ounces. One cup of fluid = 8 oz. Then convert ounces into milliliters. One ounce = 30 mL. The client's intake is:

12 oz lemon-lime soda = 360 mL

1/2 cup grape juice = 4 oz = 120 mL

Use the computer mouse to move the cursor inside the text box. Left-click on the cursor. Type in the correct intake using the number keys on the keyboard. The correct answer is 480. Do not put "mL" or any unit of measure after the number. Only the number goes into the box. Rules for rounding are typically provided with the question.

The LPN/LVN is caring for a client who has a primary health care provider order for strict intake and output. The client drinks 12 oz

of lemon-lime soda and 1/2 cup grape juice between breakfast and lunch, and voids 200 mL of urine. Calculate and record the client's oral intake in milliliters for this period.

480 mL

## Drag and Drop/Ordered Response—Arrange the Answers in the Correct Order

This is one of the newer alternate format question types introduced by the NCSTN. These questions ask you to place answers in a specific order.

Take a look at the following question.

The nurse is preparing to insert an indwelling urinary catheter in a female client. Arrange the following steps in the order the LPN/LVN should perform them. All options must be used.

Unordered Options		Ordered Response
Open the sterile pack between the client's legs.	↔	
Wipe the urinary meatus with a cotton ball saturated with cleansing solution.		
Inflate the balloon of the catheter to check for leaks.		
Place the client supine with knees flexed.		
Lubricate the tip of the catheter.		
Put on the sterile gloves.		

The strategy to use in answering this kind of question is to picture yourself performing the procedure. First, prepare the client. Next, prepare the equipment in the correct order, using sterile technique. Open the sterile insertion kit. Then, put on the sterile gloves. Next, inflate the balloon of the catheter to check for leaks. (NOTE: This step may vary per facility policy and manufacturer guidelines. Silicone catheter balloons should not be pre-inflated.). Lubricate the tip of the catheter. After preparing the equipment, prepare the client for the insertion of the catheter. The last step from those provided is to cleanse the periurethral area using swabsticks or cotton balls saturated with cleansing solution.

To place the options in the correct order, click on an option and drag it to the box on the right. You can also move an answer from the left column to the right column by highlighting the option and clicking the arrow key that

points to the column on the right. You may also rearrange the order of the options in the right column using the arrow keys pointing up and down.

Here's the answer to this question.

The nurse is preparing to insert an indwelling urinary catheter in a female client. Arrange the following steps in the order the LPN/LVN should perform them. All options must be used.

Unordered Options		Ordered Response
	↔	Place the client supine with knees flexed.
		Open the sterile pack between the client's legs.
		Put on the sterile gloves.
		Inflate the balloon of the catheter to check for leaks.
		Lubricate the tip of the catheter.
		Wipe the urinary meatus with a cotton ball saturated with cleansing solution.

# Multiple-Choice Test Questions

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Multiple-choice questions with four answer options may take the form of a traditional text-based question, or may be in the form of an alternate format question that includes an exhibit/chart, is based on an audio clip, or contains graphics in place of some of the text. No matter the form, to effectively apply the strategies discussed in this book, you need to understand the components of an NCLEX-PN® multiple-choice question. They are as follows:

- The stem of the question. The stem includes the situation that describes the client, his or her problems or health care needs, and other relevant information. It also includes a question or an incomplete statement. This is the question that you must answer.
- Three incorrect answers, referred to here as distracters.
- The correct answer.

The three distracters will probably sound logical to you. They may even be based on information provided in the stem, but they don't really answer the question. Other incorrect answers may be actions that are common nursing practice but not ideal nursing practice.

The correct answer is the only choice that is recognized as correct by the NCLEX-PN® exam, so you need to learn to select it. Remember that most

answer choices are written on the application level: you will not be able to select answers based on recognition or recall. You must understand the whys of nursing care in order to select the correct response.

Read the following exam-style question. In addition to selecting an answer, identify the components of this question.

The LPN/LVN is planning care for a 4-year-old client who has been sexually abused by the father. Play therapy is scheduled. The LPN/LVN knows that the **primary** goal of play therapy for a 4-year-old client is which of the following?

1. Provide the opportunity to express anger and hostility by playing with dolls.
2. Promote communication because the client may lack capacity to verbally express perceptions.
3. Assess whether the client function at an age-appropriate developmental level.
4. Reveal the type of abuse experienced through direct observation of the client at play.

### The Components

- The stem:
  - 4-year-old client
  - Sexually abused by the father

- Play therapy is scheduled
- What is the primary goal of play therapy for a 4-year-old client?
- The answer choices:

Provide the opportunity to express anger and hostility. Play therapy will allow children to express anger and hostility if that's what they want to communicate. Some students select this answer because they focus on the treatment of sexual abuse mentioned in the situation. This is a distracter.

Promote communication. Play is the universal language of children. The purpose of play therapy is to give children the opportunity to communicate using their own "language." This is the correct answer.

Assess her developmental level. The nurse might be able to assess whether a child is functioning at an age-appropriate level, but this is not the primary purpose of play therapy. This is a distracter.

Find out what type of abuse the client has experienced. The child might communicate the type of abuse she has experienced if that is what the child chooses to communicate. The nurse should focus on the purpose of play therapy, not the type of abuse. This is a distracter.

Let's try another question.

A client is being treated for heart failure with diuretic therapy. Which of the following findings **best** indicates to the LPN/LVN that the client's condition is improving?



1. The client's weight has remained stable since admission.
2. The client's systolic blood pressure has decreased.
3. There are fewer crackles heard when auscultating the client's lungs.
4. The client's urinary output is 1,500 mL per day.

### The Components

- The stem:
  - Heart failure
  - Treatment is diuretic therapy
  - How do you know the client's condition is improving?
- The answer choices:

Weight has remained stable. The client's weight should decrease with diuretic therapy. Weight addresses issues involved with diuretic therapy. However, it is not the best indication of improvement in a client with heart failure. This is a distracter.

The systolic blood pressure has decreased. Decreased blood pressure may be the result of diuretic therapy, but it could also be due to other causes (change of position, calm rather than an excited state, etc.). This is not the best indication of an improvement in a client with heart failure. This is a distracter.

There are fewer crackles. A client with heart failure has crackles due to pulmonary edema. Diuretics are given to promote excretion of sodium and water through the kidneys. Decreased crackles would

indicate that the pulmonary edema is improving. This is the correct answer.

Urinary output of 1,500 mL in 24 hours. This is within normal limits. Although a normal output addresses diuretic therapy, it is not the best indication of improvement of heart failure. This is a distracter.

# Critical Thinking Strategies

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- The NCLEX-PN® exam is not a test about recognizing facts.
- You must be able to correctly identify what the question is asking.
- Do not focus on background information that is not needed to answer the question.
- The NCLEX-PN® exam focuses on thinking through a problem or situation.

Now that you are more knowledgeable about the components of a multiple-choice test question, let's talk about specific strategies that you can use to problem-solve your way to correct answers on the NCLEX-PN® exam.

Remember, the NCLEX-PN® exam tests your ability to think critically. Critical thinking for the practical/vocational nurse involves:

- Observation
- Deciding what is important
- Looking for patterns and relationships
- Identifying the problem
- Transferring knowledge from one situation to another
- Applying knowledge
- Discriminating between possible choices and/or courses of action

- Evaluating according to criteria established

Are you feeling overwhelmed as you read these words? Don't be! We are going to teach you a step-by-step method to choose the appropriate path.

There are some strategies that you must follow on every NCLEX-PN® exam test question. You must always figure out what the question is asking, and you must always eliminate answer choices.

Choosing the right answer often involves choosing the best of several answers that have correct information. This may entail your correct analysis and interpretation of what the question is really asking. So let's talk about how to figure out what the question is asking.

# Reword the Question

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The first step to correctly answering NCLEX-PN® exam questions is to find out what each question is really asking.

Step 1. Read each question carefully from the first word to the last word. Do not skim over the words or read them too quickly.

Step 2. Look for hints in the wording of the question stem. The adjectives most, first, best, primary, and initial indicate that you must establish priorities. The phrase further teaching is necessary indicates that the answer will contain incorrect information. The phrase client understands the teaching indicates that the answer will be correct information.

Step 3. Reword the question stem in your own words so that it can be answered with a yes or a no, or with a specific bit of information. Begin your questions with what, when, or why. We will refer to this reworded version as THE REWORDED QUESTION in the examples that follow.

Step 4. If you can't complete step 3, read the answer choices for clues.

Let's practice rewording a question.

A preschool-age child is brought to the emergency department (ED) by the parents for treatment of a femur fracture. When asked how the injury occurred, the parents state that the child fell from the sofa. On examination, the LPN/LVN finds old and new lesions on the child's buttocks. Which of the following statements **most** appropriately reflects how the LPN/LVN should document these findings?

- 1.
- 2.
- 3.
- 4.

We omitted the answer choices to make you focus on the question stem this time. The answer choices will be provided and discussed later in this chapter.

Step 1. Read the question stem carefully.

Step 2. Pay attention to the adjectives. Most appropriately tells you that you need to select the best answer.

Step 3. Reword the question stem in your own words. In this case, it is, "What is the best documentation for this situation?"

Step 4. Because you were able to reword the question, the fourth step is unnecessary. You didn't need to read the answer choices for clues.

We have all missed questions on a test because we didn't read accurately. The following question illustrates this point.

A client is admitted to the hospital for treatment of active tuberculosis (TB). The LPN/LVN reinforces teaching about TB. Which of the following statements by the client indicates to the LPN/LVN that further teaching is necessary?

- 1.
- 2.
- 3.
- 4.

Again, just the question stem is given to encourage you to focus on rewording the question. We will discuss the answer choices for this question later in this chapter.

Step 1. Read the question stem carefully.

Step 2. Look for hints. Pay particular attention to the statement "further teaching is necessary." You are looking for negative information.

Step 3. Reword the question stem in your own words. In this case, it is, “What is incorrect information about TB?”

Step 4. Because you were able to reword the question, the fourth step is unnecessary. You didn’t need to read the answer choices for clues to determine what the question is asking.

Try rewording this test question.

A client admitted to the hospital in premature labor has been treated successfully. The client is to receive a regimen of betamethasone. Which of the following statements by the client indicates to the LPN/LVN that the client understands the teaching about the medication?

- 1.
- 2.
- 3.
- 4.

Again, just the question stem is given to encourage you to focus on rewording the question. We will discuss the answer choices for this question later in this chapter.

Step 1. Read the question stem carefully.



Step 2. Look for hints. Pay attention to the words client understands. You are looking for true information.

Step 3. Reword the question stem. This question is asking, “What is true about betametasone?”

Step 4. Because you were able to reword this question, the fourth step is unnecessary. You didn’t need to obtain clues about what the question is asking from the answer choices.



# Eliminate Incorrect Answer Choices

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Now that you've mastered rewording the question, let's examine how to select the correct answer.

Remember the characteristics of unsuccessful test takers? One of their major problems is that they do not thoughtfully consider each answer choice. They react to questions using feelings and hunches. Unsuccessful test takers look for a specific answer choice. The following strategy will enable you to consider each answer choice in a thoughtful way.

Step 1. Do not look at any of the answer choices except answer choice (1).

Step 2. Read answer choice (1). Then repeat THE REWORDED QUESTION after reading the answer choice. Ask yourself, "Does this answer THE REWORDED QUESTION?" If you know the answer choice is wrong, eliminate it. If you aren't sure, leave the answer choice in for consideration.

Step 3. Repeat the above process with each remaining answer choice.

Step 4. Note which answer choices remain.

Step 5. Reread the question to make sure you have correctly identified THE REWORDED QUESTION.

Step 6. Ask yourself, “Which answer choice best answers the question?”  
That is your answer.

Let’s practice the elimination strategy using the same questions.

A preschool-age child is brought to the emergency department (ED) by the parents for treatment of a femur fracture. When asked how the injury occurred, the parents state that the child fell from the sofa. On examination, the LPN/LVN finds old and new lesions on the child’s buttocks. Which of the following statements most appropriately reflects how the LPN/LVN should document these findings?

1. “Six lesions in various stages of healing noted on buttocks.”
2. “Multiple lesions on buttocks due to child abuse.”
3. “Lesions noted on buttocks from unknown causes.”
4. “Several lesions noted on buttocks caused by cigarettes.”

THE REWORDED QUESTION: “What is good documenting?”

Step 1. Do not look at any of the answer choices except for answer choice (1). Thoughtfully consider each answer choice individually.

Step 2. Read answer choice (1). Does it answer the question, “What is good documenting for this situation?”

“Six lesions in various stages of healing noted on buttocks.” Is this good documenting? Maybe. Leave it in for consideration.

Step 3. Repeat the process with each remaining answer choice.

“Multiple lesions on buttocks due to child abuse.” Is this good documenting? No, because the LPN/LVN is making a judgment about the cause of the lesions.

“Lesions noted on buttocks from unknown causes.” Is this good documenting? Maybe. Leave it in for consideration.

“Several lesions noted on buttocks caused by cigarettes.” Is this good documenting? No. The question does not include information about how the burns occurred.

Step 4. Answer choices (1) and (3) remain.

Step 5. Reread the question to make sure you have correctly identified THE REWORDED QUESTION. This question asks you to identify good documenting.

Step 6. Which is better documenting? “Six lesions in various stages of healing noted on buttocks,” or “Lesions noted on buttock from unknown causes”? Good documenting is accurate, objective, concise, and complete. It must reflect the client’s current status. The correct answer is (1).

Some students will select answer (3), thinking, “How can I be sure about the stages of healing?” But the purpose of this question is to test your ability to select good documenting. Select the answer choice that shows you are a safe and effective nurse. Remember, questions on the NCLEX-PN® exam are not designed to trick you. Stay focused on the question.

Let’s select the correct answer for the second question.

A client admitted to the hospital for treatment of active tuberculosis (TB). The LPN/LVN reinforces teaching about TB. Which of the following statements by the client indicates to the LPN/LVN that further teaching is necessary?

1. “I will have to take medication for 6 months.”
2. “I should cover my nose and mouth when coughing or sneezing.”
3. “I will remain in isolation for at least 6 weeks.”
4. “I will always have a positive skin test for TB.”

THE REWORDED QUESTION: What is incorrect information about TB?

Step 1. Do not look at any of the answer choices except answer choice (1).

Step 2. Read answer choice (1). Does it answer THE REWORDED QUESTION, “What is incorrect (or wrong) information about TB?”

“I will have to take medication for 6 months.” Is this wrong information? No, it is a true statement. The client will need to take a medication, such as isonicotinyl hydrazine (INH), for 6 months or longer. Eliminate this choice.

Step 3. Repeat the process with each remaining answer choice.

“I should cover my nose and mouth when coughing or sneezing.” Is this wrong information about TB? No, this is a true statement. TB is transmitted by droplet contamination. Eliminate it.

“I will remain in isolation for at least 6 weeks.” Is this wrong information about TB? Maybe. Leave it in for consideration.

“I will always have a positive skin test for TB.” Is this a wrong statement about TB? No, this is true. A positive skin test indicates that the client has developed antibodies to the tuberculosis bacillus. Eliminate this choice.

Step 4. Only answer choice (3) remains.

Step 5. Reread the question to make sure you have correctly identified THE REWORDED QUESTION. The question is, “What is incorrect information about TB?”

Step 6. The correct answer is (3). You “know” this is the correct answer because you’ve eliminated the other three answer choices. The client does not need to be isolated for 6 weeks. The client’s activities will be restricted for about 2–3 weeks after medication therapy is initiated.

A couple of things to remember when using this strategy:

- Eliminate only what you know is wrong. However, once you eliminate an answer choice, do not retrieve it for consideration. You may be tempted to do this if you do not feel comfortable with the one answer choice that is left. Resist the impulse!
- Stay focused on THE REWORDED QUESTION. How many of you have missed a question that asked for negative information because you selected the answer choice that contained correct information?

Here's another question.

A client admitted to the hospital in premature labor has been treated successfully. The client is to receive a regimen of betamethasone. Which of the following statements by the client indicates to the LPN/LVN that the client understands the teaching about the medication?

1. "As long as I receive my medication, I won't deliver prematurely."
2. "It is important that I count the fetal movements for one hour, twice a day."
3. "I have insomnia and a rapid heart beat while on this medication."
4. "Bed rest is necessary in order for the medication to work properly."

THE REWORDED QUESTION: What is true about antenatal betamethasone?

Step 1. Do not look at any of the answer choices except answer choice (1).

Step 2. Read answer choice (1). Does it answer the question, “What is true about betamethasone?”

“As long as I receive my medication, I won't deliver prematurely.” Is this true about betamethasone? No. Betamethasone will help fetal lung maturation in case the client delivers prematurely, but it doesn't prevent premature delivery. Eliminate it.

Step 3. Repeat the process with each remaining answer choice.

“It is important that I count the fetal movements for one hour, twice a day.” Is this true about betamethasone? Maybe. Clients are told to be aware of fetal movement. Keep it as a possibility.

“I may have insomnia and a rapid heart beat while on this medication.” Is this true of betamethasone? Yes. Betamethasone is a corticosteroid. Side effects include insomnia, increased maternal heart rate, and hypertension. Leave this choice in for consideration.

“Bed rest is necessary for the medication to work properly.” Is this true about betamethasone? No. Betamethasone will work whether the client is on bedrest or not. Eliminate it.

Step 4. Note that only answer choices (2) and (3) remain.

Step 5. Reread the question to make sure you are answering the right question. The question is, “What is true about betamethasone?”



Step 6. Which choice best answers the question, (2) or (3)? If you are focused on the question, you will select (3). Some students focus on the background information (pregnancy). This question has nothing to do with pregnancy. If you chose (2), you fell for a distracter.

Remember: Focus on the question, and not the background information. If you can answer the question—“What is true about betamethasone?”—without considering the background information (pregnancy), do it. Many students answer a question incorrectly because they don’t focus on THE REWORDED QUESTION. Don’t fall for the distracters.

At this point you’re probably thinking, “Will I have enough time to finish the test using these strategies?” or “How will I ever remember how to answer questions using these steps?” Yes, you will have time to finish the test. Unsuccessful test takers spend time agonizing over test questions. By using these strategies, you will be using your time productively. You will remember the steps because you are going to practice, practice, practice with test questions. You will not be able to absorb this strategy by osmosis; the process must be practiced repeatedly.

# Don't Predict Answers

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On the NCLEX-PN® exam, you are asked to select the best answer from the four choices that you are given. Many times, the “ideal” answer choice is not there. Don't sit and moan because the answer that you think should be there isn't provided. Remember:

- Identify THE REWORDED QUESTION.
- Select the best answer from the choices given.

Look at this question.

The LPN/LVN is explaining the procedure for clean-catch urine specimen collection for culture and sensitivity to a male client. Which of the following explanations by the LPN/LVN would be **most** accurate?

1. “The urinary meatus is cleansed with an iodine solution and then a urinary drainage catheter is inserted to obtain urine.”
2. “You will be asked to empty your bladder one-half hour before the test; you will then be asked to void into a container.”
3. “Before voiding, the urinary meatus is cleansed with an iodine solution and urine is voided into a sterile container; the container must not touch the penis.”
4. “You must void a few drops of urine, then stop; then void the remaining urine into a clean container, which should be immediately covered.”

Step 1. Read the question stem.

Step 2. Focus on the adjectives. “Most accurate” tells you that more than one answer may seem correct.

Step 3. Reword the question stem. What is true about a clean-catch urine specimen for culture and sensitivity?

Step 4. Read each answer choice and ask yourself, “Is this true about a clean-catch urine specimen for culture and sensitivity?”

This choice describes how to obtain a catheterized urine specimen. Urine isn’t usually collected by catheterization due to the increased risk

of infection. This answer does not answer the question about a clean-catch urine specimen. Eliminate.

This describes a double-voided specimen. This action is usually done when testing urine for glucose and ketones. It is not relevant to a clean-catch urine specimen. Eliminate.

This is true of a clean-catch urine specimen for culture and sensitivity. The urinary meatus is cleansed, a sterile container is used, and the penis must not touch the container. Leave this answer in for consideration.

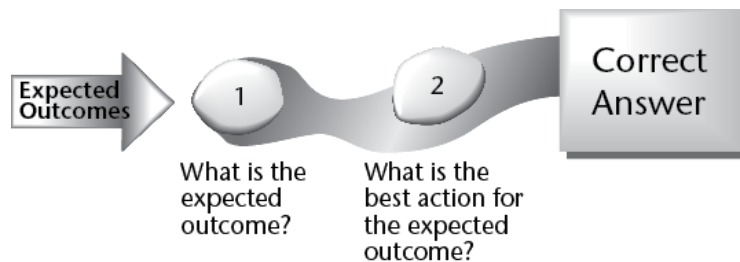
This does describe a clean-catch urine specimen. The client does void a few drops of urine, stops, and then continues voiding into the container. There is only one problem. For a culture and sensitivity, the container must be sterile. Eliminate.

The correct answer is (3). Many students will select answer choice (4) because they see the expected words: “Void a few drops, stop, continue voiding.” Be careful. This question is a good example of why scanning for expected words could get you into trouble. You may see expected words in an answer choice that is not correct.

Okay. You’ve practiced how to identify the topic of the question and how to eliminate answer choices. You know that predicting answers does not work on the NCLEX-PN® exam. You are well on your way to correctly answering NCLEX-PN® exam test questions. Unfortunately, this is just the starting point. Let’s talk about specific paths and how you can correctly decide which paths to use on the NCLEX-PN® exam. Remember, the correct answer is at the end of the path!

# Recognize Expected Outcomes

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You spent much of your time in practical/vocational nursing school learning about what might go wrong with clients and their care. This makes sense; after all, nurses need to deal with problems and illnesses. Many test questions that your practical/vocational nursing school faculty wrote focused on what was wrong with clients and their care. In order to prove minimum competence, the beginning practical/vocational nurse must demonstrate the ability to make appropriate nursing judgments. Competent nursing judgments include recognizing both expected and unexpected behaviors, so it is important for you to recognize expected outcomes on the NCLEX-PN® exam. Expected outcomes are the behaviors and changes you think are going to occur as a result of nursing care. These outcomes allow the nurse to evaluate whether goals have been met.

Look at the following question.

The LPN/LVN is checking the morning's serum electrolyte results for a client. The LPN/LVN notes that the client's sodium is 142 mEq/L (142 mmol/L), potassium is 4.4 mEq/L (4.4 mmol/L), and chloride is 102 mEq/L (102 mmol/L). Which of the following should the nurse do **first**?

1. Encourage the client to drink additional fluids.
2. Notify primary health care provider of electrolyte results.
3. Record electrolyte results in the client's medical record.
4. Withhold the client's potassium supplement.

If this question were included on one of your fundamentals tests, you would assume that a problem was being described. You would choose an answer that involved “fixing” the problem. Let’s look at this question.

THE REWORDED QUESTION: What should you do with a client with these electrolyte results?

Step 1. Recognize normal. Interpret the serum electrolyte results. All are within normal limits.

Step 2. Decide how you should use this information. Because the values are all normal, let’s reword the question again using this information.

Now THE REWORDED QUESTION is: What should you do for a client with normal serum electrolytes?

ANSWERS:

Encourage the client to drink additional fluids. Although good fluid intake is usually recommended, this is not a priority because the serum electrolytes are within normal limits. Eliminate.

Notify the physician of the client's electrolyte results. This is unnecessary because the serum electrolytes are normal. Most physicians request notification only for abnormal test results. Eliminate.

Record the electrolyte results in the client's chart. This action should be done because the electrolyte results are normal.

Withhold the client's morning potassium supplement. The client's  $K^+$  is within normal limits, which suggests that the potassium supplement has helped maintain this serum level. There is no indication with the information you have been given that this would be necessary or prudent. Eliminate.

The correct answer is (3). The electrolytes are within normal limits. Some students select answer choice (1) because they think there's something they missed, or it must be a trick question. The "trick" is deciding whether the information that you are given is normal or abnormal, and then answering the question accordingly.

Try this question.

A client reporting chest pressure is brought to the emergency department (ED). Vital signs include blood pressure is 150/90 mm Hg, pulse 88 beats/minute, respirations 20 breaths/minute. The LPN/LVN administers nitroglycerin 0.4 mg sublingually as ordered. After five minutes, the client's vital signs include, blood pressure is 100/60 Hg, pulse 96 beats/minute, respirations 20 breaths/minute. Which of the following actions should the LPN/LVN take next?

1. Notify the primary health care provider of hypotension.
2. Place the client in semi-Fowler's position and administer oxygen at 4 L/minute.
3. Administer a second dose of nitroglycerin 0.4 mg sublingually, as ordered.
4. Document vital signs and continue to monitor the client.

THE REWORDED QUESTION: What should you do for this client?

To answer this question you need to know what these vital signs indicate.

Step 1. Recognize normal. Nitroglycerin is a potent vasodilator with anti-anginal, anti-ischemic, and antihypertensive actions. It increases blood flow through the coronary arteries. Side effects include orthostatic hypotension, tachycardia, dizziness, and palpitations. Decreased blood



pressure, increased pulse rate, and stable respiratory rate after administration of a potent vasodilator is normal and expected.

Step 2. Decide how you should use this information. The question should be reworded as, “What should you do for a client who has responded as expected to a dose of nitroglycerin?”

#### ANSWERS:

Notify the primary health care provider of hypotension. The blood pressure has decreased due to vasodilation. Decreased blood pressure is expected. Eliminate.

Place the client in semi-Fowler’s position and administer oxygen at 4L/minute. Respiratory rate is stable and there is no indication of respiratory distress. Eliminate.

Administer a second dose of nitroglycerin 0.4 mg sublingually, as ordered. The nurse should assess the client for chest pain first, and administer a second dose of the medication only if the client continues to report chest pain. Eliminate.

Document the vital signs and continue to closely monitor the client. This is the correct choice. You identified it by recognizing the client’s response as normal, thus eliminating the other three answer choices.

The correct answer is (4). You would expect a client’s blood pressure to decrease after administration of nitroglycerin. The key to this question is understanding how the medication works and correctly identifying the expected outcome.

# Read Answer Choices to Obtain Clues

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Because the NCLEX-PN® exam tests your critical thinking, the topic of the questions may be unstated. You may see a question that concerns a disease process or procedure with which you are unfamiliar. Most test takers who are “clueless” about a question will read the question and answer choices over and over again. They do this because they hope that:

- They will remember seeing the topic in their notes or on a textbook page.
- The light will dawn and they will remember something about the topic.
- They believe there is some clue in the question that will point them toward the correct answer.

What usually happens? Absolutely nothing! The student then randomly selects an answer choice. When you randomly select an answer, you have one chance in four of getting it right. You can better those odds, and here's how: when you encounter a question that deals with unfamiliar nursing content, look for clues in the answer choices instead of in the question stem.

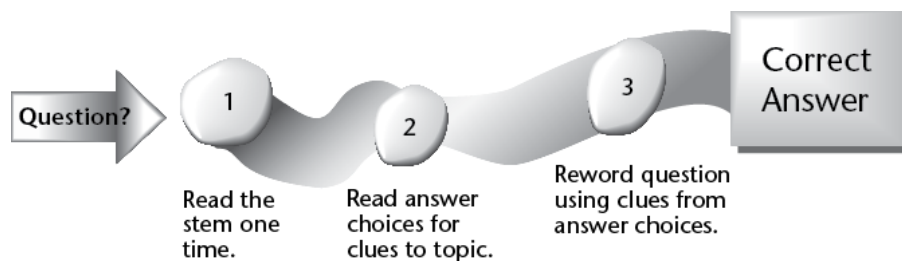
If you find yourself “clueless” after you carefully read a question, follow these steps:

Step 1. Resist the impulse to read and reread the question. Read the question only once. Identify the topic of the question. It is often unstated.

Step 2. Read the answer choices, not to select the correct answer, but to figure out, “What is the topic of the question?” or “What should I be thinking?” You are looking for clues from the answer choices.

Step 3. After reading the answer choices, reword the question using the clues that you have obtained.

Step 4. Then use the strategies previously discussed to answer the question you have formulated.



Let's try this strategy with a question.

A client with type 1 diabetes contacts the home care LPN/LVN to report nausea and abdominal pain. The LPN/LVN should advise the client to do which of the following?

1. “Hold your regular dose of insulin.”
2. “Check your blood glucose level every 3 to 4 hours.”
3. “Increase consumption of foods containing simple sugars.”
4. “Increase your activity level.”

Step 1. Read the stem of the question. Can you identify the topic of the question? No, you can't. The LPN/LVN is telling the client to do something, but about what topic? The topic is unstated in the question.

Step 2. Read the answer choices to obtain clues about the topic of the question. Each answer choice deals with ways to maintain a normal blood glucose.

Step 3. Reword the question. “What does the LPN/LVN tell the client about ‘sick day rules’?”

ANSWERS:

“Hold your regular dose of insulin.” This is an implementation that would increase the blood glucose level. The LPN/LVN should collect data first. Eliminate.

“Check your blood glucose level every 3 to 4 hours.” This is data collection. Before you can advise the client, you must identify whether the client is hypoglycemic or hyperglycemic. Keep this answer for consideration.

“Increase your consumption of foods containing simple sugars.” This is an implementation and would increase the client’s blood glucose level. The LPN/LVN should collect data first. Eliminate.

“Increase your activity level.” This is an implementation that would decrease the client’s blood glucose level. The LPN/LVN should collect data first. Eliminate.

The nurse should always collect data before implementing nursing care. The correct answer is (2).

No matter how much you prepare for the NCLEX-PN® exam, there may be topics you see on your test with which you are unfamiliar. Reading the answer choices for clues will increase your chances of selecting a correct answer. Remember, you do have a body of knowledge. You just have to be calm and access this knowledge.

Read this question.

A client is being treated for Addison’s disease. The primary health care provider orders cortisone 25 mg PO daily. The LPN/LVN should explain to the client that a dosage adjustment may be required in which of the following situations?

1. Dosage is increased when the blood glucose level increases.
2. Dosage is decreased when dietary intake is increased.
3. Dosage is decreased when infection stimulates endogenous steroid secretion.
4. Dosage is increased relative to an increase in the level of stress.

Not sure what Addison's disease is? Not sure how to adjust the dose of cortisone?

Step 1. Read the question once. Resist the impulse to reread the question.

Step 2. Read the answer choices. What should you be thinking? The question concerns cortisone. If the client is receiving cortisone, Addison's disease must be something that requires cortisone, a hormone from the adrenal glands. You notice that dosages are both increased and decreased.

Step 3. Use these clues to find the answer to THE REWORDED QUESTION, "What is true about adjusting cortisone dosage?"

Dosage is increased when the blood glucose level increases. Is this true about cortisone? No. This sounds like insulin. Eliminate.

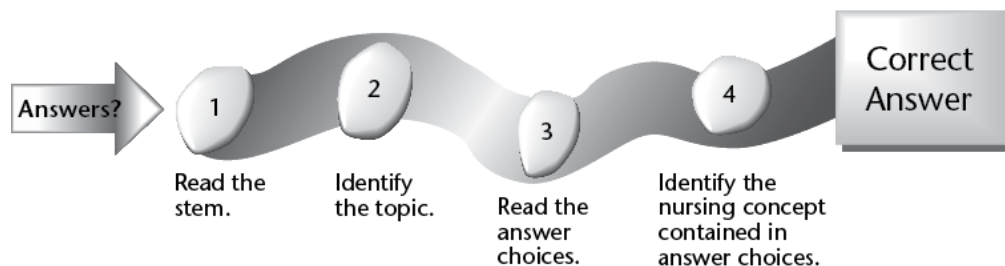
Dosage is decreased when dietary intake is increased. Is this true about cortisone? No. Cortisone requirements are not related to diet. Eliminate.

Dosage is decreased when infection stimulates endogenous steroid secretion. Endogenous means “within the client.” If the client is receiving cortisone for Addison’s disease, the client must have adrenal insufficiency. Therefore, infection can’t stimulate steroid secretion. Eliminate.

Step 4. The correct answer is (4) because it is the only choice remaining. Even if you are not confident that cortisone is increased during periods of stress, you can conclude that this is the correct answer because the other choices have been eliminated.

If you’re not sure about the topic of the question, read the answer choices for clues.

Let’s look at another path.



In some questions, the NCLEX-PN® exam asks you to figure out the topic of the question. In other questions, you are required to use critical thinking skills to figure out what the answer choices really mean. The NCLEX-PN® exam can take a concept with which you are very familiar and make it difficult to recognize. The following question illustrates this point.

A client with a history of heart failure visits the clinic. The client states, “I have not been feeling like my old self for about 2 weeks.” It would be **most** important for the LPN/LVN to ask which of the following questions?

1. “Do your ankles swell at the end of the day?”
2. “How do you position yourself for sleep?”
3. “How do you feel after you eat dinner?”
4. “Do you have chest pain when you inhale?”

It is not difficult to identify the topic of this question, “What is a priority for a client with heart failure?” Many students get tripped up on this question by not thinking through the answers as carefully as they should. In some questions, you have to figure out the topic of the question. In this question, you have to figure out what the answer choices mean.

Step 1. Read the stem of the question.

Step 2. Reword the question in your own words.

Step 3. Read the answer choices.

Step 4. Think: “What nursing concept should I identify in the answer choices?”

THE REWORDED QUESTION: What is a priority for a client with heart failure?



## ANSWERS:

“Do your ankles swell at the end of the day?” Why would you ask a client this question? Because edema is a symptom of right-sided heart failure. Is right-sided failure your priority? No, left-sided failure takes priority because it affects the lungs. Eliminate this answer.

“How do you position yourself for sleep?” Why would you ask a client this question? If the client sleeps flat in bed, breathing is not compromised. If the client sleeps in a recliner, the client experiences orthopnea, a symptom of left-sided failure. This would be a priority. Keep this answer for consideration.

“How do you feel after you eat dinner?” Why would you ask a client this question? Bloating after meals is a symptom of right-sided failure. This is not as important as breathing problems. Eliminate this answer.

“Do you have chest pain when you inhale?” Why would you ask a client this question? It does indicate a breathing problem. The student who reacts rather than thinks may select this answer. Pain on inspiration may indicate irritation of the parietal pleura of the lung, which is not associated with heart failure. Eliminate this answer.

The correct answer is (2). In order to select this answer, you must recognize that “Where do you sleep at night?” represents orthopnea. The NCLEX-PN® exam can take important concepts such as this and “hide” the concept in some fairly simple behaviors.

Let’s try another question where you have to figure out what the answer choices really mean.

The LPN/LVN is caring for a client immediately after a paracentesis. It is **most** important for the LPN/LVN to ask which of the following questions?

1. “Do your clothes feel tight?”
2. “Do you need to void?”
3. “Are you feeling dizzy?”
4. “Do you have any pain?”

Step 1. Read the stem of the question.

Step 2. Reword the question in your own words.

Step 3. Read the answer choices.

Step 4. Think: “What nursing concept should I identify in the answer choices?”

THE REWORDED QUESTION: What is the highest priority for a client after a paracentesis?

ANSWERS:

“Do your clothes feel tight?” Why would you ask a client this question? Clothes should fit looser because the abdominal girth has decreased after fluid has been removed with a paracentesis. This is an expected outcome. Eliminate.

“Do you need to void?” Why would you ask a client this question? It is imperative to empty the bladder prior to the procedure, not after the procedure. There is no compelling reason to ask the client this question. Eliminate.

“Are you feeling dizzy?” What makes a client dizzy? One of the causes is a decrease in cerebral perfusion due to a fall in blood pressure. Could this client have a decreased blood pressure? Yes. Hypotension and hypovolemic shock are complications of a paracentesis due to removal of a large volume of fluid. Keep this answer for consideration.

“Do you have any pain?” You ask this question to assess pain level. This client may have discomfort where the paracentesis was performed, but this is an expected outcome. Eliminate.

The correct answer is (3).

These questions illustrate why knowing nursing content is not enough to answer application/analysis-level questions. You must be able to effectively use the information you learned in practical/vocational nursing school to answer NCLEX-PN® exam-style test questions. Review the lessons that you learned in this chapter:

- Reword the question.
- Eliminate answer choices you know to be incorrect.
- Don’t predict answers.
- Recognize expected outcomes.
- Read answer choices to obtain clues.

## Chapter Quiz

1. The LPN/LVN is reinforcing teaching for a client after a right mastectomy and axillary lymph node dissection. Which statement by the client requires further intervention by the LPN/LVN? Select all that apply.

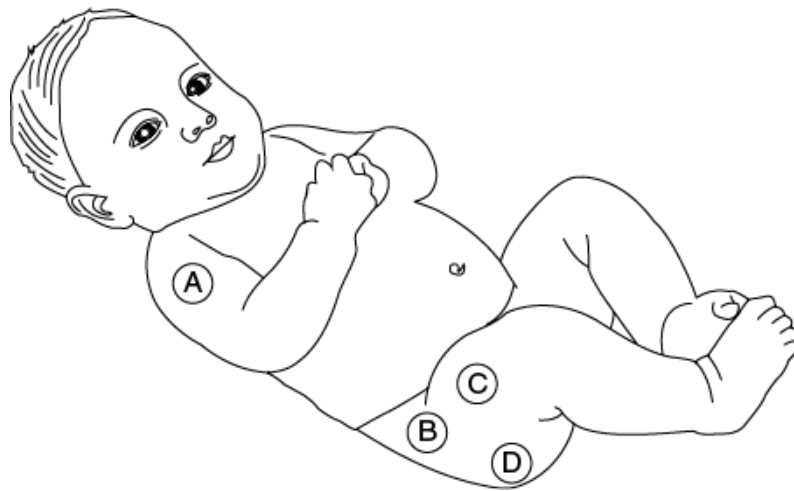
- (A) "I will wear gloves and long sleeves whenever I go out and work in my garden."
- (B) "The risk for arm swelling will decrease one year after my treatment is completed."
- (C) "I will sleep with my right arm elevated on a small flat pillow from now on."
- (D) "If my right arm begins to feel heavy, I should contact my primary health care provider."
- (E) "It will be necessary for me to wear a compression bandage for the rest of my life."

2. The LPN/LVN is preparing to reinforce instructions for a client about the use of an incentive spirometer. Arrange the following steps in the order the client should perform them. All options must be used.

- (A) Seal lips around the mouthpiece.
- (B) Assume high Fowler's position.
- (C) Exhale slowly and cough.
- (D) Hold breath for 3 to 5 seconds.
- (E) Inhale slowly and deeply.

3. The LPN/LVN is preparing to infuse 1 L of normal saline solution at a rate of 125 mL/hr. The drop factor for the intravenous tubing is 15 drops per mL. What is the drip rate per minute? Round to the nearest whole number. \_\_\_\_\_ gtt/minute

4. The LPN/LVN is preparing to administer an intramuscular injection to a 6-month-old client. Identify the area where the injection should be given.



- (A) A.
- (B) B.
- (C) C.
- (D) D.

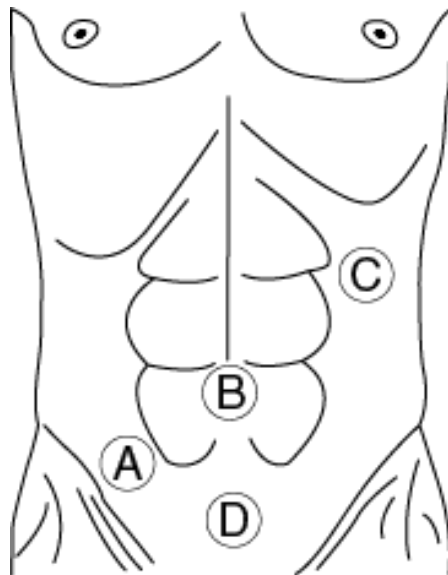
5. The LPN/LVN is caring for a client diagnosed with Parkinson's disease. The LPN/LVN observes that the client has tremors of the hands and slurred speech. The family reports that the client appears depressed. What is the priority of care for this client?

- (A) Place a clock and calendar within the client's view in room.
- (B) Encourage the client to perform range-of-motion exercises.
- (C) Ask the family about the client's favorite television shows.
- (D) Assist client to sit on the edge of the bed before ambulation.

6. The client is waiting to be picked up by family members after a cystogram. The LPN/LVN is reinforcing teaching about the client's home care for the first 48 hours. Which of the following instructions is appropriate for the LPN/LVN to include? Select all that apply.

- (A) Decrease water and other fluid intake.
- (B) Avoid consuming alcoholic beverages.
- (C) Seek medical attention for a slight burning sensation when voiding.
- (D) Seek medical attention for the appearance of blood in the urine.
- (E) Apply heat to the lower abdomen to relieve pain and muscle spasm.
- (F) Report fever, chills, or increased pulse to the primary health care provider.

7. The LPN/LVN is caring for the client who has just undergone surgery for an inflamed appendix. The surgeon made a traditional incision directly over the organ removed. Identify the area where the LPN/LVN would check for bleeding and infection.



- (A) A.
- (B) B.
- (C) C.
- (D) D.

8. The LPN/LVN is preparing to give an immobile client a bedpan. Arrange the following steps in the order that the LPN/LVN should perform them. All options must be used.

- (A) Cover the client with bed linens for privacy.
- (B) Help lift the client by placing one hand under the client's lower back.
- (C) Ask the client to flex the knees and raise the buttocks.
- (D) Put on a clean pair of examination gloves.
- (E) Raise the opposite side rail to prevent the client from falling out of bed.
- (F) Place the bedpan on the bed so that the client's buttocks rest on the rim.

9. The LPN/LVN is explaining how to estimate sodium intake to a client prescribed the DASH diet. The DASH diet limits daily sodium intake to 1,500 mg, which must account for sodium in food and added to food. A quarter-teaspoon of salt contains 500 mg of sodium. What is the maximum total amount of salt that the client could ingest per day, in teaspoons? \_\_\_\_\_ teaspoons



10. The LPN/LVN is caring for a client diagnosed with possible liver damage following a motor vehicle accident. Which of the following actions by the LPN/LVN reflects appropriate care for this client?

Select all that apply.

- (A) Prepare for client's inability to self-bathe.
- (B) Make sure the side rails are up at all times.
- (C) Report the client's nosebleed to the unit charge nurse immediately.
- (D) Report the client's constipation to the nurse manager immediately.
- (E) Remove the hospital bed pillow to help the client lie flat.
- (F) Inspect the client's skin and eye color for signs of jaundice.



## Answers and Explanations

## CHAPTER QUIZ

### 1. The Answer is 2, 3, and 5

The LPN/LVN is reinforcing teaching for a client after a right mastectomy and axillary lymph node dissection. Which statement by the client requires further intervention by the LPN/LVN? Select all that apply.

Strategy: First, identify the topic of the question. If unable to identify the topic after reading the question, read the answers for clues. All answers relate to prevention of lymphedema. Note that the client had a right mastectomy. When a question includes a reference to left or right, that is often important for identifying the correct answer.

Then, rephrase each answer choice as a “yes/no” question that asks “Will this action by the client prevent lymphedema?” Be careful! The question asks which statements require further intervention by the LPN/LVN. You are looking for incorrect statements.

Category: Evaluation/Physiological Integrity/Reduction of Risk Potential

Will wearing gloves and long sleeves while gardening prevent lymphedema? Yes. Any injury to the right arm, including insect bites or scrapes, may become infected and cause lymphedema. This is a correct action. Eliminate.

CORRECT: Will arm swelling decrease one year after the mastectomy procedure? No. The client is at risk for lymphedema for the rest of her life. This statement is not true. Select this answer.

CORRECT: Will arm elevation on a small flat pillow decrease the risk of lymphedema? No. The arm should be elevated above the level

of the heart at night. It is an incorrect action. Select this answer.

Arm heaviness is a sign of lymphedema development. Client instruction includes notifying primary health care provider if the involved arm feels heavy, has decreased muscle function, or has numbness and tingling. This is a correct action. Eliminate.

CORRECT: Will a client need to wear a compression bandage for the rest of her life? No. Compression bandages may be used if the client develops acute lymphedema. Compression bandages are not routinely used after mastectomy and lymph node dissection. Select this answer.

2. The Answer is 2, 1, 5, 4, 3

The LPN/LVN is preparing to reinforce instructions for a client about the use of an incentive spirometer. Arrange the following steps in the order the client should perform them. All options must be used.

Strategy: Picture the client using the incentive spirometer. What is the purpose of incentive spirometry? To open the alveoli and lower airway passages and increase oxygenation. What position enables the client to inhale deeply to promote lung expansion? The upright position (2).

Now think about the steps used for incentive spirometry. Before the client inhales through the mouthpiece, there must be a tight seal (1). To make the volume indicator move, the client must inhale slowly and deeply (5). To achieve maximum expansion of the lungs, the client should hold the inhalation for 3 to 5 seconds (4). The last step is slow exhalation (3), which will continue to promote expansion of the lower airways.

Category: Planning/Physiological Integrity/Reduction of Risk Potential

Assume high Fowler's position.  
Seal lips around the mouthpiece.  
Inhale slowly and deeply.  
Hold breath for 3 to 5 seconds.  
Exhale slowly and cough.

3. The answer is 31

The LPN/LVN is preparing to infuse 1 L of normal saline solution at a rate of 125 mL/hr. The drop factor for the intravenous tubing is 15 drops per mL. What is the drip rate per minute? Round to the nearest whole number.

Strategy: Apply the conversion equations, being careful to avoid calculation errors. Only the numerical drip rate should be recorded.  
Note that specific rounding instructions are given.

Category: Planning/Physiological Integrity/Pharmacological Therapies

The formula is:

$$\frac{\text{mL/hr} \times \text{drop factor}}{\text{time in minutes}}$$

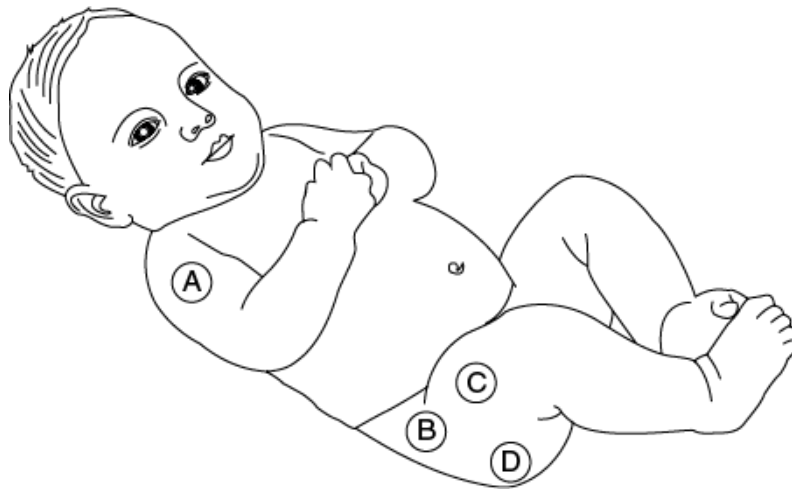
For this problem, you need to convert the hour to 60 minutes:

$$\frac{125 \text{ mL/hr} \times 15 \text{ gtt/min}}{60 \text{ min}} = \frac{1,875}{60} = 31.25 \text{ gtt/min}$$

Round to the nearest whole number. The correct answer is 31.

4. The Answer is 3

The LPN/LVN is preparing to administer an intramuscular injection to a 6-month-old client. Identify the area where the injection should be given.



Strategy: To answer this hot spot question, recall the age of the client (6 months old) and the preferred site for intramuscular injections in infants (the vastus lateralis muscle in the thigh). Then think about the anatomical landmarks necessary to locate the correct site.

Category: Implementation/Physiological Integrity/Pharmacological Therapies

A: The deltoid muscle is not the correct location.

B: The hip is not the correct location.

CORRECT: Location C is correct. For infants, IM injection should be given in the middle third of the anterior thigh, between the midline

anterior thigh and the midline lateral thigh. To identify the IM injection site, locate the greater trochanter, then the knee joint; divide the area between the trochanter and the knee joint into thirds and note the middle third; then locate the area between the midline anterior thigh and the midline of the outer aspect of the thigh.

D: The buttock is not the correct location.

5. The Answer is 4

The LPN/LVN is caring for a client diagnosed with Parkinson's disease. The LPN/LVN observes that the client has tremors of the hands and slurred speech. The family reports that the client appears depressed. What is the priority of care for this client?

Strategy: The client has hand tremors, slurred speech, and depression, but the topic of this question is unknown. Read the answers for clues: The question asks about priority of care. Remember that physical and safety needs take priority over psychosocial needs.

Category: Implementation/Safe and Effective Care Environment/Safety and Infection Control

Place a clock and calendar within the client's view in room—This is a psychosocial answer. Although clients diagnosed with Parkinson's disease can have cognitive impairment, other answers relate to physical or safety needs. Eliminate.

Encourage the client to perform range-of-motion exercises—This is a physical answer. Think about what you know about Parkinson's disease: Clients can develop muscle rigidity, and range of motion

exercises may help with that. Is it a priority of care? Keep for consideration.

Ask the family about the client's favorite television shows—This is a psychosocial answer. Eliminate.

CORRECT: Assist client to sit on the edge of the bed before ambulation—This is a safety answer. Clients diagnosed with Parkinson's disease are at risk for orthostatic hypotension due to autonomic dysfunction. Does this answer make sense? Yes. Select this answer. The important concept in this question is safety, which is a priority over psychosocial needs.

#### 6. The Answer is 2, 5, and 6

The client is waiting to be picked up by family members after a cystogram. The LPN/LVN is reinforcing teaching about the client's home care for the first 48 hours. Which of the following instructions is appropriate for the LPN/LVN to include? Select all that apply.

Strategy: For each answer choice, identify the outcome for the client.

Category: Implementation/Health Promotion and Maintenance/Self-Care

Decrease water and other fluid intake—The client needs to increase, not decrease, water and other fluid intake.

Avoid consuming alcoholic beverages—CORRECT: The excretion of alcoholic beverages might irritate the bladder, so it is advisable to avoid them for 2 days.

Seek medical attention for a slight burning sensation when voiding—A slight burning sensation when voiding can be expected as



a normal, not emergency, outcome.

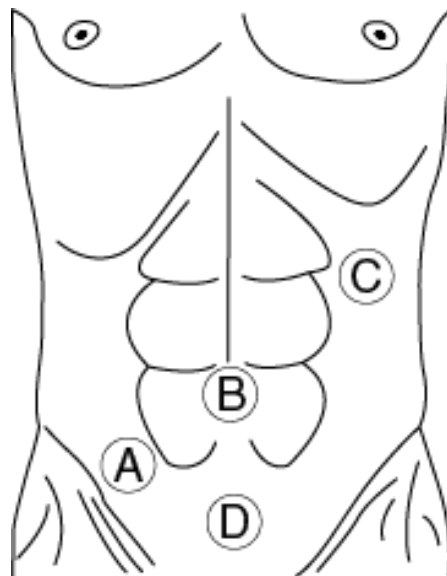
Seek medical attention for the appearance of blood in the urine—Minor bleeding during the first 2 days can occur without being a cause for immediate concern.

CORRECT: Apply heat to the lower abdomen to relieve pain and muscle spasm—Heat can relieve the pain and muscle spasm that are normal after the cystogram.

CORRECT: Report fever, chills, or increased pulse to primary health care provider—Fever, chills, or an increased pulse could signify an infection; the clinician should be notified.

7. The Answer is 1

The LPN/LVN is caring for the client who has just undergone surgery for an inflamed appendix. The surgeon made a traditional incision directly over the organ removed. Identify the area where the LPN/LVN would check for bleeding and infection.



Strategy: Examine the diagram carefully. Locate the appendix. Know the client's right side from left side.

Category: Implementation/Physiological Integrity/Physiological Adaptation

CORRECT: Location A is correct. The lower right-hand side of the abdomen is directly over the organ removed.

B: The umbilicus is a possible site of a laparoscopic incision, not a traditional surgical incision.

C: The upper left-hand side of the abdomen is not used for either a traditional or a laparoscopic incision to remove an inflamed appendix.

D: The groin is a possible site of a laparoscopic incision, not a traditional surgical incision.

8. The Answer is 4, 5, 3, 2, 6, 1

The LPN/LVN prepares to give the nonmobile client a bedpan. Arrange the following steps in the order that the LPN/LVN should perform them. All options must be used.

Strategy: Visualize the client's body in bed. Picture yourself performing the procedure step by step.

Category: Planning/Physiological Integrity/Basic Care and Comfort

Put on a clean pair of examination gloves.

Raise the opposite side rail to prevent the client from falling out of bed.

Ask the client to flex the knees and raise the buttocks.

Help lift the client by placing one hand under the client's lower back.

Place the bedpan on the bed so that the client's buttocks rest on the rim.

Cover the client with bed linens for privacy.

9. The answer is 0.75

The LPN/LVN is explaining how to estimate sodium intake to a client prescribed the DASH diet. The DASH diet limits daily sodium intake to 1,500 mg, which must account for sodium in food and added to food. A quarter-teaspoon of salt contains 500 mg of sodium. What is the maximum total amount of salt that the client could ingest per day, in teaspoons?

Strategy: Apply the conversion equation. Be careful to avoid calculation errors.

Category: Data Collection/Physiological Integrity/Basic Care and Comfort

Each quarter-teaspoon of table salt contains 500 mg sodium, and the daily maximum is 1,500 mg:

$$1,500 \text{ mg} \div 500 \text{ mg} = 3$$

$$3 \times \frac{1}{4} \text{ teaspoon} = \frac{3}{4} \text{ teaspoon} = 0.75 \text{ teaspoon}$$

10. The Answer is 3 and 6

The LPN/LVN is caring for a client diagnosed with possible liver damage following an motor vehicle accident. Which of the following actions by the LPN/LVN reflects appropriate care for this client? Select all that apply.

Strategy: Consider the outcome of each answer choice. Does it contribute to appropriate care?

Category: Implementation/Physiological Integrity/Reduction of Risk Potential

Prepare for client's inability to self-bathe—The clinical situation has not given any indication that the client will need assistance in bathing.

Make sure the side rails are up at all times—The clinical situation does not suggest that the client is a fall risk.

CORRECT: Report the client's nosebleed to the unit charge nurse immediately—Bleeding, especially from the nose and the rectum, is consistent with internal organ damage, including liver damage.

Report the client's constipation to the nurse manager immediately—Constipation is not a symptom to cause immediate concern.

Remove the hospital bed pillow to help the client lie flat—The client does not have to lie flat in bed to heal.

CORRECT: Inspect the client's skin and eye color for signs of jaundice—A yellow cast on the skin or yellowed whites of the eyes are consistent with jaundice.

## CHAPTER 4

# THE NCLEX-PN<sup>®</sup> EXAM VERSUS REAL-WORLD NURSING

Some of you are CNAs or other unlicensed assistive personnel (UAPs) completing your practical/vocational nursing studies, while others are EMTs. Some of you worked during school as student techs. All of you, however, spent time in clinical during your practical/vocational nursing education. All of this adds up to a lot of experience. Experience will help you get a job, but answering questions based on your experience can be dangerous on the NCLEX-PN<sup>®</sup> exam.

Look at the following question.

On admission to the hospital, an elderly client is confused and appears disheveled and restless. During the client's second day on the unit, an LPN/LVN approaches the client to administer medication. The LPN/LVN is unable to identify the client because the identification band is missing. Which of the following actions by the LPN/LVN is **best**?

1. Have the roommate identify the client.
2. Ask the client to state the full name.
3. Ask another LPN/LVN to identify the client.
4. Look at photograph in client's medical record.

Let's see how someone using his or her real-world experience would approach this question:

"The roommate is never involved in identification of a client."

"A confused client cannot be relied on for an accurate identification."

"Sounds reasonable. I have seen this done in some circumstances."

"A photograph? What photograph? I've never seen a photograph of a client in a medical record!"

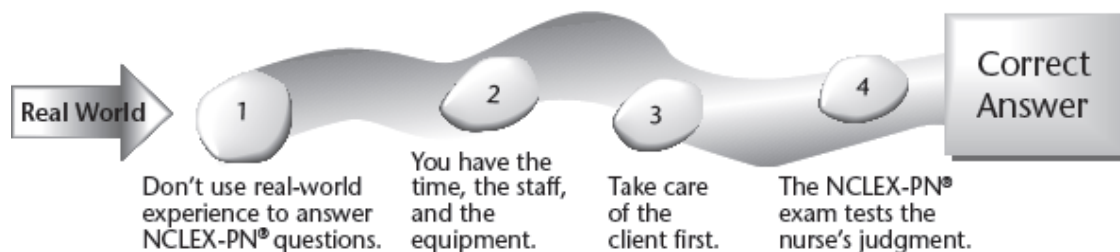
Possible conclusions drawn by this person would include: "OK, I've seen one LPN/LVN ask another for information so (3) must be the answer," or "Well, maybe the client isn't all that confused, so I'll select (2)."

According to nursing textbooks, asking another health care professional is not the correct way to identify a client. Many acute-care settings now include a photograph of the client in the medical record for just this type of situation. The correct answer to this question is (4). Many students reject this answer because there are rarely photographs of clients in the medical records. Real-world experience doesn't count, though; in this case, the client does have a photograph in the medical record.

The NCLEX-PN<sup>®</sup> exam is a standardized exam administered by the NCSBN. Because the NCLEX-PN<sup>®</sup> exam is a national exam, students should be aware

that in some parts of the country, practical/vocational nursing is practiced slightly differently. However, to ensure that the test is reflective of national trends, questions and answers are all carefully documented. The test makers ensure that the correct answers are documented in at least two standard nursing textbooks or one textbook and one nursing journal.

When you are unsure of an answer choice, don't ask yourself, "What do they do on my floor?" but "What does the medical/surgical textbook writer Brunner say?" or "What do Potter and Perry say to do?" This test does not necessarily reflect what happens in the "real world," but is based on textbook nursing.



Remember the following when taking the NCLEX-PN® exam:

- You have all of the time and resources you need to provide appropriate care to your client. (Checking for bowel sounds for 5 minutes in all four quadrants, no problem!)
- You have all of the equipment you need. (Remember the bath thermometer you learned to use in the nursing lab? For the NCLEX-PN® exam, you will have one available to test the temperature of bath water.)
- There are no staffing problems on the NCLEX-PN® exam. You are caring only for the client described in the question, and that person is your only concern.

- All care given to clients is “by the book.” No shortcuts are used.

Answer the following question.

The LPN/LVN is preparing an agitated and confused client for surgery. For preoperative medication, the LPN/LVN administers morphine sulfate 5 mg IM and lorazepam 0.5 mg IM, as prescribed. The LPN/LVN should take which of the following precautions after the preoperative medication is administered?

1. Ask the security guard to remain with the client.
2. Have the unlicensed assistive personnel (UAP) remain with client.
3. Leave the client alone until the medications take effect.
4. Restrain the client with the help of a coworker.

Let's look at this using real-world logic.

Ask the security guard to stay with the client. Yes, in the real world, security is called when clients are agitated.

Have UAP remain with the client. Sounds good, but what if you don't have enough staff to assign a UAP to remain with the client?

Leave the client alone until the medications take effect. Yes, that is done in the real world for most medicated preoperative clients, but this client is agitated and confused. This is not the best answer.



Restrain the client with the help of a coworker. Yes, this is done in the real world.

According to real-world logic, the correct answer must be (1) or (4). However, textbook theoretical nursing practice states that this client should not be left alone while in an agitated state. A member of the health care staff should remain with the client. Therefore, the correct answer is (2).

Use your real-world experience to help you visualize the client described in the test question, but select your answers based on what is found in nursing textbooks.

Your nursing faculty has been very conscientious about instructing you in the most up-to-date nursing practice. According to the National Council of State Boards of Nursing, the primary source for documenting correct answers is in nursing textbooks, and the most up-to-date practice might not always agree with the textbooks. When in doubt, always select the textbook answer!

The next question illustrates this point.

A client is admitted to the hospital in active labor. After delivery of a healthy infant, the client decides to bottle-feed. Which of the following statements by the client after a teaching session indicates to the LPN/LVN that the client needs further instruction?

1. “I’ll pump my breasts and use warm packs to relieve breast pain.”
2. “I’ll wear a tight bra and apply ice packs to relieve engorgement discomfort.”
3. “I’ll take the prescribed pain medication when I have pain or discomfort.”
4. “I’ll take the prescribed pills to help stop the production of milk.”

Let’s look at these answers more closely.

Pumping the breasts will stimulate milk production. This is clearly wrong.

Wearing a tight bra and using ice packs are appropriate interventions for a nonbreastfeeding mother.

Taking a medication (mild analgesic) is an appropriate intervention for a nonbreastfeeding mother.

Medication to prevent lactation is not frequently prescribed because of potentially dangerous side effects. However, a medication may be prescribed to prevent lactation. This would be considered an appropriate intervention.

The correct answer is (1).

# First Take Care of the Client, Then the Equipment

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The NCLEX-PN® exam tests your ability to use critical thinking skills to make nursing judgments. It is very important that you remember to:

- Take care of the client first.
- Take care of the equipment second.

Look at the following question.

A client who sustained a left femur fracture in a motor vehicle accident is being treated with balanced-suspension skeletal traction using a Thomas splint and a Pearson attachment. The client reports “terrible” pain in the left thigh. Which of the following should the LPN/LVN do **first**?

1. Determine that the traction weights and ropes are aligned and hanging free.
2. Ask the client about the characteristics and location of the pain.
3. Check the Thomas splint and Pearson attachment for proper positioning.
4. Explain to client that pain in the affected leg is expected.

Let's review the answers:

Determine that traction weights and ropes are aligned and hanging free. This answer choice has you checking the equipment, not the client. Your first concern should be the client, not the traction. Eliminate this answer.

Ask the client about the characteristics and location of the pain. This answer choice focuses on the client first. Pain should be thoroughly investigated by the LPN/LVN. Keep in this answer for consideration.

Check the Thomas splint and Pearson attachment for proper positioning. This answer choice also has you checking the equipment, not the client. Your first concern should be the client. Eliminate.

Explain to client that pain in the affected leg is expected. Any reports of pain should be thoroughly investigated by the LPN/LVN, because complaints of pain are considered abnormal. Eliminate.

The correct answer is (2).

# Laboratory Values

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Answering questions about laboratory values is another example of how the real world does not work on the NCLEX-PN® exam. In practical/vocational nursing school, you learned laboratory values for specific tests and you may not have remembered them after the test. While you were in the clinical setting, the emphasis was on interpretation of laboratory values. Because most lab slips contained a listing of normal values, you were able to compare the client's results to the normal values. Questions on the NCLEX-PN® exam will not provide you with a listing of normal laboratory values.

To answer questions on the NCLEX-PN® exam, you must:

- Know normal laboratory test results.
- Correctly interpret normal or abnormal laboratory test results.

Compare the following two questions.

A client is admitted to the hospital with influenza-like symptoms. When taking the client's history, the LPN/LVN learns that the client had been taking digoxin 0.125 mg PO daily and furosemide 40 mg PO daily for 3

years. Last month the primary health care provider changed the prescription for digoxin to 0.25 mg daily. The LPN/LVN would expect the primary health care provider to prescribe which of the following laboratory tests?

1. Serum electrolyte and digoxin levels.
2. Hemoglobin level and hematocrit.
3. Cardiac enzymes and arterial blood gas analysis.
4. Blood culture and sensitivity and urinalysis.

Most of you are probably familiar with the concepts presented in this question. The primary health care provider has increased the client's digoxin dose. Furosemide is a loop diuretic that inhibits resorption of sodium and chloride; side effects include hypotension, hypokalemia, GI upset, and weakness. Hypokalemia may increase the client's risk of digitalis toxicity. Serum electrolytes and digoxin level (1) is the correct answer.

Now look at this question.

The LPN/LVN is caring for a client admitted with fever, vomiting, and diarrhea. The LPN/LVN sees the following nursing diagnosis on the client's care plan: "fluid volume deficit." Which of the following changes in laboratory test results would demonstrate an improvement in the client's condition?

1. Urine specific gravity, 1.015; hematocrit, 37% (0.37).
2. Urine specific gravity, 1.020; hematocrit, 45% (0.45).
3. Urine specific gravity, 1.032; hematocrit, 52% (0.52).
4. Urine specific gravity, 1.025; hematocrit, 35% (0.35).

To correctly answer this question, you must know:

- Normal urine specific gravity ranges 1.010–1.030 and normal hematocrit ranges 42–50% (0.42–0.50) for a male, 40–48% (0.40–0.48) for a female
- How fluid volume deficit affects hematocrit and specific gravity

Fluid volume deficit occurs when fluids and electrolytes are lost in the same proportion as they exist in the body. When a client becomes dehydrated, both the urine specific gravity and hematocrit become elevated. The correct answer is (2).

Answer this question:

A client is hospitalized with a diagnosis of atrial fibrillation. The primary health care provider prescribes heparin 5,000 units every 12 hours to be given by subcutaneous injection and a daily partial thromboplastin time (PTT). The result of the client's

most recent PTT is 55 seconds. Which of the following actions should be taken by the LPN/LVN?

1. Document the results and administer the heparin.
2. Withhold the heparin.
3. Notify the primary health care provider of the test results.
4. Have the test repeated.

To answer this question you need to know:

- Normal PTT ranges 20–45 seconds.
- Therapeutic range PTT for a client receiving heparin, an anticoagulant, ranges 1.5–2 times the control or normal level.
- To calculate the therapeutic range, take the lower number for the normal range for a PTT (20) and multiply it by 1.5. The result is 30. Multiply the higher number (45) by 2. The result is 90. Thus the therapeutic range ranges from 30 to 90 seconds. Therapeutic PTT ranges 30 to 90 seconds, the goal of therapy.

Evaluate the answer choices:

“Document the results and administer the heparin.” The client’s most recent PTT is 55 seconds. This falls within the therapeutic range of 30 to 90 seconds, so the LPN/LVN should administer the medication.

“Withhold the heparin.” A side effect of heparin is bleeding, which can occur when PTT rises above therapeutic range. If the PTT measures



greater than 90 seconds, the nurse should notify the primary health care provider.

“Notify the primary health care provider of the test results.” There is no reason to notify the primary health care provider, since the PTT falls within the therapeutic range.

“Have the test repeated.” There is no reason to have the test repeated, since it falls within normal range.

The correct answer is (1).



# Medication Administration

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An important function in providing safe and effective care to clients is the administration of medications. Because this is one of the responsibilities of a beginning LPN/LVN, questions about medications are often an important part of the NCLEX-PN<sup>®</sup> exam. The LPN/LVN who is minimally competent is knowledgeable about medications and uses the “rights” medication administration.

In nursing school, most questions about medication followed the same pattern. You were told the client’s diagnosis, the name of the medication, and then were asked a question. Even if you didn’t know the information about the medication, sometimes you were able to select the correct answer by knowing the diagnosis.

The NCLEX-PN<sup>®</sup> exam does not give you any clues from the context of the question. The questions on this exam include the name of the medication, usually identifying it by generic name only. Most of the time, you will not be given the reason the client is receiving the medication.

Let’s look at some medication questions.

The primary health care provider orders furosemide and spironolactone for a client. Prior to administering the medication, the LPN/LVN determines that the client's potassium is 3.2 mEq/L (3.2 mmol/L). In addition to notifying the supervising RN, the LPN/LVN should anticipate taking which of the following actions?

1. Hold either the furosemide or spironolactone.
2. Administer the spironolactone only.
3. Administer the furosemide only.
4. Administer the furosemide and spironolactone.

This is a typical exam-style medication question. The question concerns the side effects and nursing implications of furosemide and spironolactone.

“Hold either the furosemide or spironolactone.” The potassium level falls below normal (3.5–5 mEq/L [3.5–5 mmol/L]). Furosemide is a potassium-wasting diuretic, and spironolactone is a potassium-sparing diuretic. There is no reason to hold the spironolactone because the client has a low potassium level. Eliminate this answer.

“Administer the spironolactone only.” The spironolactone should be administered.

“Administer the furosemide only.” Do not administer the furosemide because it is a potassium-wasting diuretic. The client's potassium level is already low. Eliminate.

“Administer the furosemide and spironolactone.” Do not administer the furosemide. Eliminate.

The correct answer is (2).

Let’s try this next question.

A client returns to the clinic 2 weeks after being started on allopurinol 200 mg PO daily. The LPN/LVN reviews information about this medication with the client. Which of the following statements by the client indicates that the teaching was effective?

1. “I should take my medication on an empty stomach.”
2. “I should take my medication with orange juice.”
3. “I should increase my daily intake of protein.”
4. “I should drink at least 8 glasses of water daily.”

To answer this question you need to know information about allopurinol, an antigout agent that reduces uric acid.

“I should take my medication before eating.” Allopurinol is best tolerated with or immediately after meals to reduce gastrointestinal (GI) irritation. Eliminate.

“I should take my medication with orange juice.” Orange juice makes the urine acidic. Allopurinol is more soluble in alkaline urine. Eliminate.

“I should increase my daily intake of protein.” It is not necessary to increase the intake of protein when taking allopurinol. Eliminate.

“I should drink at least 8 glasses of water daily.” Allopurinol can cause kidney stones. The client should drink 3,000 mL/day to reduce the risk of renal calculi formation.

The correct answer is (4). You must know the side effects and nursing implications of medications for the NCLEX-PN® exam.

# Notify the Primary Health Care Provider

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Another behavior that commonly occurs in the real world is notifying the primary health care provider. In nursing school you were encouraged to notify your instructor of changes in your client's condition. Be very careful how you handle this on the NCLEX-PN® exam. More often than not, the answer choice that states “notify the primary health care provider,” “contact the social worker,” or “refer to the chaplain” is the WRONG answer. Usually there is something you need to do first before you notify them. The NCLEX-PN® exam does not want to know what the primary health care provider is going to do. The NCLEX-PN® exam wants to know what you, the LPN/LVN, will do in a given situation.

Answer this question.

The LPN/LVN notes that there is no urine in the client's urinary drainage bag 3 hours after the bag was last emptied. Which of the following actions should the LPN/LVN take **first**?

1. Check for kinks in urinary drainage tubing.
2. Insert a new indwelling urinary catheter.
3. Irrigate existing indwelling urinary catheter.
4. Notify client's primary health care provider.

THE REWORDED QUESTION: What should you do first for this client? Have this client's kidneys stopped producing urine? Is there an obstruction in the urinary drainage system?

"Check for kinks in urinary drainage tubing." If there is no urine in the urinary drainage bag, could there be an obstruction in the drainage system? Checking for kinks in the urinary drainage tubing could provide a simple explanation for your observations.

"Insert a new indwelling urinary catheter." Inserting a new indwelling urinary catheter may address a possible catheter obstruction but increases the client's risk for catheter-associated urinary tract infection. Are you sure you want to do this first?

"Irrigate existing indwelling urinary catheter." Irrigating the indwelling urinary catheter in hopes of dislodging a possible obstruction increases the client's risk for catheter-associated urinary tract infection. Are you sure you want to do this first?

"Notify client's primary health care provider." If you notify the client's primary health care provider of "no urinary output in 3 hours" as your first action, will you be able to answer potential questions regarding the client's lack of urine output? Are you transferring your responsibility to the primary health care provider? Is there something YOU should do first?

The correct answer is (1).

Before you choose the answer choice that involves “call the primary health care provider,” look at the other answer choices very carefully. Make sure that there isn’t an answer that contains data collection or an action you should take before making the phone call. The test makers want to know what you would do in a situation, not what the primary health care provider would do!

Here is one more real-world question.

The LPN/LVN is approached in the elevator by an employee from another unit. The employee states that a close friend is a client on the LPN/LVN’s unit. The employee asks about the friend's condition and laboratory test results. The LPN/LVN should do which of the following?

1. Answer employee’s questions softly to prevent others from overhearing.
2. Refuse to discuss the friend’s medical condition with the employee.
3. Refer the employee to the client's primary health care provider for information.
4. Tell the employee the client's normal test results.



THE REWORDED QUESTION: What should an LPN/LVN do when asked about a client by a hospital employee?

“Answer employee’s questions softly to prevent others from overhearing”. Discussing client information in a public place breaches confidentiality. Eliminate.

“Refuse to discuss the friend’s medical condition with the employee.” This does not violate the client’s right to privacy and confidentiality. Keep in consideration.

“Refer the employee to the client's primary health care provider for information.” Providing any information about a client to someone not directly involved in the client’s care breaches privacy. Eliminate.

“Tell the employee the client's normal test results.” Sharing any information without the client's permission breaches confidentiality. Eliminate.

The correct answer is (2).

Expect to see real-world situations on your NCLEX-PN® exam, but make sure that you do not choose real-world answers! These strategies should help you use your previous nursing experience without encountering any pitfalls.

# Chapter Quiz

1. Two hours after the insertion of a Salem sump nasogastric (NG) tube, the client vomits a moderate amount of yellow-green fluid. What is the most appropriate action for the LPN/LVN to take?
  - (A) Inject 30 mL air and auscultate the left upper quadrant.
  - (B) Instill 20 mL carbonated beverage into the drainage tube.
  - (C) Inform the primary health care provider of the vomiting.
  - (D) Irrigate nasogastric (NG) tube with 20 mL normal saline.
  
2. The LPN/LVN is caring for a client after a motor vehicle accident. The LPN/LVN observes that the client is restless, anxious, and has tremors of the hands. The family reports that the client has consumed 4 to 6 beers a day for the past 8 years. What is the priority action for the LPN/LVN to take?
  - (A) Reorient client to the environment frequently.
  - (B) Maintain the client in a cool, darkened room.
  - (C) Assist the client to drink more isotonic fluids.
  - (D) Administer thiamine 100 mg intramuscularly.
  
3. The LPN/LVN is preparing to administer isoniazid 300 mg PO. Which of the following is a priority laboratory value to monitor before administering the medication?

- (A) B-type natriuretic peptide (BNP).
- (B) Aspartate aminotransferase (AST).
- (C) Potassium.
- (D) Vitamin B12.

4. The LPN/LVN is reinforcing instructions for a client taking clopidogrel 75 mg PO daily. Which statement by the client indicates understanding of the reinforced instructions?

- (A) "It will be necessary for me to have frequent blood tests done now."
- (B) "I will need to discontinue the garlic tablets I take to control cholesterol."
- (C) "I can continue to take several ibuprofen a day for my low back pain."
- (D) "I will need to make sure I take a daily multivitamin tablet now."

5. The LPN/LVN is caring for a child whose parent reports that the child experienced abdominal cramps and diarrhea after ingesting milk. Which of the following test results would rule out the diagnosis of lactose intolerance?

- (A) Random serum glucose level 20 mg/dL (1.1 mmol/L) greater than the fasting serum glucose level.
- (B) Random serum glucose level 20 mg/dL (1.1 mmol/L) less than the fasting serum glucose level.
- (C) Fasting serum glucose level results are equal to the random serum glucose level results.
- (D) Fasting serum glucose level 10 mg/dL (0.56 mmol/L) greater than the random serum glucose level.

6. The LPN/LVN is preparing a primigravid client for a primary health care provider examination. Laboratory test results are available. Which fasting serum glucose level result would indicate that gestational diabetes is likely?

- (A) Serum glucose level of 40 mg/dL (2.2 mmol/L).
- (B) Serum glucose level of 100 mg/dL (5.5 mmol/L).
- (C) Serum glucose level of 140 mg/dL (7.7 mmol/L).
- (D) Serum glucose level of 180 mg/dL (9.9 mmol/L).

7. The primary health care provider prescribed phenytoin 100 mg PO q.i.d. for the client. Prior to administering the second dose, the LPN/LVN observes that the client appears lethargic and has nystagmus and slurred speech. In addition to notifying the supervising RN, the LPN/LVN should do which of the following?

- (A) Administer the phenytoin to prevent an impending seizure.
- (B) Administer the phenytoin to prevent cardiac arrhythmia.
- (C) Withhold the phenytoin due to signs of an allergic reaction.
- (D) Withhold the phenytoin because client show signs of toxicity.

8. The LPN/LVN is reviewing medication information with a female client who has been prescribed sertraline daily. Which of the following statements by the client indicates a need for further instruction?

- (A) "I will continue to take my birth control pills."
- (B) "If these pills don't work in 2 weeks, I will stop taking them."
- (C) "I will take my pill first thing in the morning."
- (D) "I will skip a missed dose if it is almost time for my next one."

9. Within 5 minutes of beginning a blood transfusion, the client reports feeling hot and diaphoretic, and the LPN/LVN observes that the client appears flushed. Which of the following actions should the nurse take first?

- (A) Notify primary health care provider.
- (B) Stop blood transfusion immediately.
- (C) Increase normal saline solution drip rate.
- (D) Obtain the client's vital signs immediately.

10. The client comes to the urgent care clinic reporting “I’ve just stepped on a rusty nail at a construction site.” The LPN/LVN observes a deep puncture wound on the sole of the right foot. What order would the nurse expect to receive from the primary health care provider for this client?

- (A) Complete blood count.
- (B) Wound culture.
- (C) Tetanus vaccine.
- (D) Lumbar puncture.



## Answers and Explanations

## CHAPTER QUIZ

### 1. The Answer is 4

Two hours after the insertion of a Salem sump nasogastric (NG) tube, the client vomits a moderate amount of yellow-green fluid. What is the most appropriate action for the LPN/LVN to take?

Strategy: Read the question and answer choices to identify the topic: possible obstruction of the NG tube. As you can see, the answers are a mix of assessment and implementation actions.

Recall the best standard of care according to nursing textbooks, and consider appropriate actions that may be taken before contacting the primary health care provider. What action can be taken immediately with least risk of injury to the client?

Category: Implementation/Physiological Integrity/Reduction of Risk Potential

Injecting air into the NG tube while auscultating over the stomach is no longer an accepted standard of care for verifying NG tube placement. Eliminate.

This may be a “real world” answer. Instilling a carbonated beverage to clear an NG tube obstruction is no longer an accepted standard of care. It has not been proven effective.

If contacted, the primary health care provider will want to know what actions have been taken. Does another answer choice describe actions within LPN/LVN scope of practice that can be taken first? Keep for consideration.



CORRECT: Irrigation with normal saline is an appropriate standard of care, is a safe action, and may clear the obstruction. Select this answer.

2. The Answer is 1

The LPN/LVN is caring for a client after a motor vehicle accident. The LPN/LVN observes that the client is restless, anxious, and has tremors of the hands. The family reports that the client has consumed 4 to 6 beers a day for the past 8 years. What is the priority action for the LPN/LVN to take?

Strategy: First, consider the symptoms described in the question: They are early signs of alcohol withdrawal. What is the priority when caring for a client during early alcohol withdrawal? Safety of the client and safety of others.

Next, determine which answer choice decreases the risk of injury to the client. When answering questions about safety, do not read into the answers or apply “real world” answers. Answer based on standards of care described in nursing textbooks.

Category: Planning/Safe and Effective Environment/Safety and Infection Control

CORRECT: A client may experience hallucinations during alcohol withdrawal. Reorienting the client to the environment helps maintain client safety during hallucinations.

Some light is recommended to decrease the intensity of the hallucinations. Bright lighting is not recommended, but soft lighting

allows the client to observe the surroundings.

Alcohol withdrawal places the client at risk for dehydration, but fluid administration does not decrease the risk of injury. Remember the topic of the question: safety.

Thiamine is a vitamin (B1), and it may be administered to correct nutritional deficiencies and treat malnutrition. But it does not decrease the risk of injury.

### 3. The Answer is 2

The LPN/LVN is preparing to administer isoniazid 300 mg PO. Which of the following is a priority laboratory value to monitor before administering the medication?

Strategy: The topic of the question is adverse effects of isoniazid (INH). Recall that isoniazid has the potential to cause liver injury. Which laboratory test indicates liver function?

Category: Data Collection/Physiological Integrity/Reduction of Risk Potential

B-type natriuretic peptide (BNP) is a hormone produced by the heart. Levels increase when heart failure develops or worsens. BNP is not related to liver injury.

CORRECT: Aspartate aminotransferase (AST) increases in the presence of liver injury. Liver function must be monitored in clients taking isoniazid.

Serum potassium levels are not affected by liver injury.

Vitamin B12 levels are not affected by liver function.

4. The Answer is 2

The LPN/LVN is reinforcing instructions for a client taking clopidogrel 75 mg PO daily. Which statement by the client indicates understanding of the reinforced instructions?

Strategy: The topic is client understanding of instructions about clopidogrel. You are looking for a correct statement. Eliminate incorrect answers.

Category: Evaluation/Physiological Integrity/Pharmacological Therapies

Clopidogrel inhibits platelet function, however, routine blood test are not needed.

CORRECT: Is there a possible interaction between garlic and clopidogrel? Yes. Both substances inhibit platelet function and increase the risk of bleeding. This statement indicates understanding.

Both ibuprofen and clopidogrel inhibit platelet function and increase the risk of bleeding. This statement does not indicate understanding of the drug interaction.

While there is no contraindication to a multivitamin tablet, it is not specifically recommended when a client takes an antiplatelet medication.

5. The Answer is 1

The LPN/LVN is caring for a child whose parent reports that the child experienced abdominal cramps and diarrhea after ingesting milk. Which of the following test results would rule out the diagnosis of lactose intolerance?

Strategy: “Rule out” means you need to identify normal laboratory values to eliminate the diagnosis.

Category: Evaluation/Physiological Integrity/Reduction of Risk Potential

CORRECT: Lactose intolerance prevents the conversion of lactose into glucose. If test results show a random serum glucose level significantly greater (20 mg/dL [1.1 mol/L]) than the fasting serum glucose level, then lactose is being converted into glucose; this rules out the diagnosis of lactose intolerance.

Without significant exercise or activity to decrease the random serum glucose level, the fasting serum glucose level is never higher than the random serum glucose level.

Lactose is not converting into glucose, so the results confirm the diagnosis of lactose intolerance.

Without significant exercise or activity to decrease the random serum glucose level, the fasting glucose level is never higher than the random serum glucose level.

6. The Answer is 4

The LPN/LVN is preparing a primigravid client for a primary healthcare provider examination. Laboratory test results are available. Which fasting serum glucose level result would indicate that gestational diabetes is likely?

Strategy: Recall that the normal serum blood glucose level in a pregnant client can rise to 140 mg/dL (7.7 mmol/L). Then identify the abnormal (higher) value.

Category: Evaluation/Physiological Integrity/Reduction of Risk Potential

Serum glucose level of 40 mg/dL (2.2 mmol/L) indicates severe hypoglycemia; a cause should be investigated.

Serum glucose level of 100 mg/dL (5.5 mmol/L) is a normal level for an adult female client.

Serum glucose level of 140 mg/dL (7.7 mmol/L) is the upper limit of a normal serum glucose level for a pregnant client.

CORRECT: Serum glucose level of 180 mg/dL (9.9 mmol/L); serum glucose level needs to be above 140 mg/dL (7.7 mmol/L) to suggest gestational diabetes.

7. The Answer is 4

The primary health care provider prescribed phenytoin 100 mg PO q.i.d. for the client. Prior to administering the second dose, the LPN/LVN observes that the client appears lethargic and has nystagmus and slurred speech. In addition to notifying the supervising RN, the LPN/LVN should do which of the following?

Strategy: Identify the cause of the client's signs and symptoms as possible diphenylhydantoin (Dilantin) toxicity.

Category: Evaluation/Physiological Integrity/Pharmacological Therapies

Lethargy, nystagmus, and slurred speech do not indicate an impending seizure.

Although the phenytoin has antiarrhythmic properties, the client's findings suggest phenytoin toxicity.

Lethargy, nystagmus, and slurred speech are not characteristic of an allergic reaction.

CORRECT: Lethargy, nystagmus, and slurred speech suggest phenytoin toxicity. The drug should be withheld.

8. The Answer is 2

The LPN/LVN is reviewing medication information with a female client who has been prescribed sertraline daily. Which of the following statements by the client indicates a need for further instruction?

Strategy: Be careful! You are looking for incorrect information.

Category: Evaluation/Physiological Integrity/Pharmacological Therapies

Sertraline can cause birth defects if taken during pregnancy; the client should continue contraceptives during therapy.

CORRECT: Sertraline may take 4 weeks to have a positive effect on the client's symptoms; the client should not stop taking the medication without consulting with the primary healthcare provider.

It is important to take the medication at the same time each day, but it does not have to be taken in the morning.

A missed dose of sertraline should be omitted if it is almost time for the next dose.

9. The Answer is 2

Within 5 minutes of beginning a blood transfusion, the client reports feeling hot and diaphoretic, and the LPN/LVN observes that the client appears flushed. Which of the following actions should the nurse take first?

Strategy: Priority question: Think about which action is most important for a client with a possible complication from treatment.

Category: Planning/Physiological Integrity/Reduction of Risk Potential

The primary health care provider can be notified after the correct actions have taken place.

CORRECT: The blood transfusion must be discontinued immediately to avoid the risk of kidney damage resulting from the possible red blood cell destruction.

The LPN/LVN needs to keep the IV catheter patent with normal saline solution but should not use the normal saline solution attached to the Y-administration set tubing, because it may contain residual red blood cells that are incompatible with the client's blood type.

After stopping the transfusion, the LPN/LVN should obtain the client's vital signs.

10. The Answer is 3

The client comes to the urgent care clinic reporting "I've just stepped on a rusty nail at a construction site." The LPN/LVN observes a deep puncture wound on the sole of the right foot. What order would the nurse expect to receive from the primary health care provider for this client?

Strategy: Consider whether testing provides any needed information about the client's status. Determine whether collecting data or implementing treatment is the priority.

Category: Planning/Physiological Integrity/Physiological Adaptation

A complete blood count is unnecessary because the client has not suffered significant blood loss.

Wound culture is not necessary for a new wound.

CORRECT: A deep puncture wound provides an ideal reservoir for the growth of *Clostridium tetani* (common in soils, dust, and feces and on human skin). To prevent tetanus, a potentially fatal bacterial infection, the primary health care provider would order the tetanus vaccine.

A primary health care provider uses lumbar puncture to withdraw spinal fluid from the spinal column for analysis. It is used to identify conditions of the brain or spine, not to manage a puncture wound in the foot.



## CHAPTER 5

# STRATEGIES FOR PRIORITY QUESTIONS

One of the biggest challenges facing you as a candidate for practical/vocational nursing licensure is to correctly answer priority questions. You will recognize these questions because they will ask you what is the “best,” “most important,” “first,” or “initial” response by the nurse.

Take a look at this sample question.

An hour after admission to the nursery, the LPN/LVN observes a newborn having spontaneous, jerky limb movements. The newborn’s mother had gestational diabetes mellitus (GDM) during pregnancy. Which of the following actions should the LPN/LVN take **first**?

1. Administer dextrose water.
2. Call the primary health care provider immediately.
3. Determine the blood glucose level.
4. Observe the newborn for associated symptoms.

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As you read this question you are probably thinking, “All of these look right!” or “How can I decide what I will do first?” The panic sets in as you try to decide what the best answer is when they all seem “correct.”

As a licensed practical/vocational nurse, you will be caring for clients who have multiple problems and needs. You must be able to establish priorities by deciding which needs take precedence over other needs. You probably recognized the newborn’s spontaneous, jerky limb movements as a sign of hypoglycemia. Don’t forget that an important part of the data collection process is validating what you observe. You must complete data collection before you plan and implement nursing care. The correct answer is (3).

The following situation might sound familiar: You are called to a client’s room by a family member and find the client lying on the floor. The client is bleeding from a wound on the forehead, and the indwelling urinary catheter is dislodged and hanging from the side of the bed. Where do you begin? Do you call for help? Do you return the client to bed? Do you apply pressure to the cut? Do you reinsert the catheter? Do you notify the primary health care provider? What do you do first? This is why establishing priorities is so important.

Your nursing faculty recognized the importance of teaching you how to establish priorities. They required you to establish priorities both in clinical situations and when answering test questions. These are the type of questions that practical/vocational nursing students find most controversial.

Here is an example of a nursing school test question:

Which of the following would most concern the LPN/LVN during a client's recovery from surgery?

- ) Safety.
- ) Hemorrhage.
- ) Infection.
- ) Pain control.

A conversation in class with your instructor may then go something like this:

Instructor: "The correct answer is (2)."

Student: "Why isn't infection the correct answer? It says right here [pointing to textbook] that infection is a major complication after surgery!"

Instructor: "Yes, infection is an important concern after surgery. But, if the client has a life-threatening hemorrhage, then the fact that the wound is infected is immaterial."

Student: "But it says here on page 106 that infection is a major complication after surgery. You can't count this answer wrong!"

In some situations, the faculty member will give you partial credit for your answer, or will "throw the question out" because there is more than one right answer. But you won't get the opportunity to argue about questions on the NCLEX-PN® exam. You either select the answer the test makers are looking for, or you get the question wrong. In the question given, all of the answers listed are important when caring for a postoperative client, but only one answer is the best.

The critical thinking required for priority questions is for you to recognize patterns in the answer choices. By recognizing these patterns, you will know which path you need to choose to correctly answer the question. This chapter will present several strategies to help you establish priorities on the NCLEX-PN® exam:

- Maslow strategy
- Nursing process strategy
- Safety strategy

We will outline each strategy, describe how and when it should be used, and show you how to apply these strategies to exam-style questions. By using these strategies, you will be able to eliminate the second-best answer and correctly identify the highest priority.

# Strategy One: Maslow

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Maslow's hierarchy of needs (Figure 1) is crucial to establishing priorities on the NCLEX-PN® exam. Maslow identifies five levels of human needs: physiological, safety and security, love and belonging, self-esteem, and self-actualization.



Figure 1: Maslow's Hierarchy of Needs

Because physiological needs are necessary for survival, they have the highest priority and must be met first. Physiological needs include oxygen, fluid, nutrition, temperature, elimination, shelter, rest, and sex. If you don't

have oxygen to breathe or food to eat, you really don't care if you have stable psychosocial relationships!

Safety and security needs can be both physical and psychosocial. Physical safety includes decreasing what is threatening to the client. The threat may be an illness (myocardial infarction), accidents (a parent transporting a newborn in a car without using a car seat), or environmental threats (the client with COPD who insists on walking outside in 10° F [-12° C] temperatures).

To attain psychological safety, the client must have the knowledge and understanding about what to expect from others in his or her environment. For example, it is important to teach the client and his family what to expect after a stroke. It is also important that you allow a woman preparing for a mastectomy to verbalize her concerns about changes that might occur in her relationship with her partner.

To achieve love and belonging, the client needs to feel loved by family and accepted by others. When a client feels self-confident and useful, he will achieve the need of self-esteem as described by Maslow.

The highest level of Maslow's hierarchy of needs is self-actualization. To achieve this level, the client must experience fulfillment and recognize his or her potential. In order for self-actualization to occur, all of the lower-level needs must be met. Because of the stresses of life, lower-level needs are not always met, and many people never achieve this high level of functioning.

## The Maslow Four-Step Process

The first strategy to use in establishing priorities is a four-step process, beginning with Maslow's hierarchy. To use the Maslow strategy, you must first recognize the pattern in the answer choices.

Step 1. Look at your answer choices.

Determine if the answer choices are both physical and psychosocial. If they are, apply the Maslow strategy detailed in Step 2.

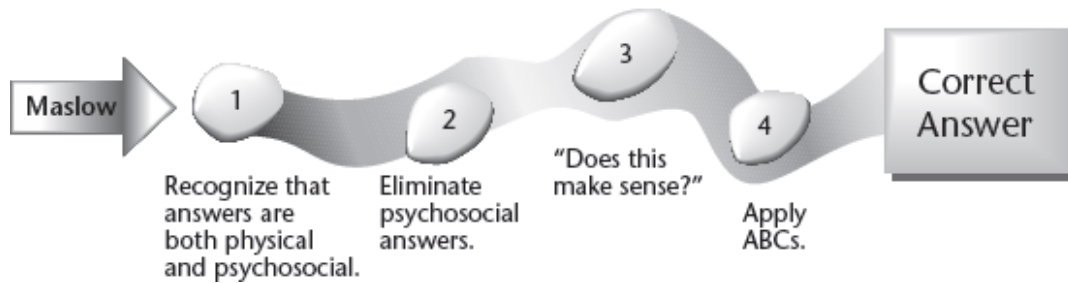
Step 2. Eliminate all psychosocial answer choices. If an answer choice is physiological, don't eliminate it yet. Remember, Maslow states that physiological needs must be met first. Although pain certainly has a physiological component, reactions to pain are considered "psychosocial" on this exam and will become a lower priority.

Step 3. Look at each of the answer choices that you have not yet eliminated and ask yourself if the answer choice makes sense with regard to the disease or situation described in the question. If it makes sense as an answer choice, keep it for consideration and go on to the next choice.

Step 4. Can you apply the ABCs?

Look at the remaining answer choices. Can you apply the ABCs? The ABCs stand for airway, breathing, and circulation. If there is an answer that involves maintaining a patent airway, it will be correct. If not, is there a choice that involves breathing problems? It will be correct. If not, go on with the ABCs. Is there an answer pertaining to the cardiovascular system?

It will be correct. What if the ABCs don't apply? Compare the remaining answer choices and ask yourself, "What is the highest priority?" This is your answer.



Let's apply this technique to a few sample exam-style test questions.

A client is admitted to the hospital with a ruptured ectopic pregnancy. A laparotomy is scheduled. Preoperatively, which of the following interventions is **most** important for the LPN/LVN to include on the client's plan of care?

1. Fluid replacement.
2. Therapeutic communication.
3. Emotional support.
4. Oxygen therapy.

Look at the stem of the question. The words most important mean:

- This is a priority question.



- There probably will be more than one answer choice that is a correct nursing action, but only one step will be the most important or highest priority action.

Step 1. Look at the answer choices.

You see that both physical and psychosocial interventions are included. Apply the Maslow strategy.

Step 2. Eliminate the answer choices that are psychosocial interventions.

Answer choice (2), which is therapeutic communication, should be discarded. Remember, therapeutic communication falls under psychosocial interventions on the NCLEX-PN® exam. Answer choice (3), emotional support, is also a psychosocial concern. Eliminate this answer. You have now eliminated two of the possible choices. You are halfway there!

Step 3. Now look at the remaining answer choices and ask yourself whether they make sense.

Answer choice (1), fluid replacement, makes sense, because this client has a ruptured ectopic pregnancy. An ectopic pregnancy is implantation of the fertilized ovum in a site other than the endometrial lining, usually the fallopian tube. Initially, the pregnancy is normal, but as the embryo outgrows the fallopian tube, the tube ruptures, causing extensive bleeding into the abdominal cavity. Answer choice (4), oxygen therapy, does not make sense with a ruptured ectopic pregnancy. The obstetrical client is not

likely to need respiratory care prior to surgery. Eliminate this answer choice.

You are left with the correct answer, (1). After reading this question, many students select answer choices (2) or (3) as the correct answer. They justify this by emphasizing the importance of managing this client's emotional distress or addressing her grief about losing the pregnancy. Neither answer choice takes priority over the physiological demand of fluid replacement prior to surgery.

Ready for another question? Try this one.

The LPN/LVN is implementing care for an adolescent client diagnosed with anorexia nervosa. On admission, the girl weighs 82 lb (37 kg) and is 5'4" (162 cm) tall. Laboratory test results indicate severe hypokalemia, anemia, and dehydration. The LPN/LVN should give which of the following nursing diagnoses the **highest** priority?

1. Body image disturbance related to weight loss.
2. Self-esteem disturbance related to feelings of inadequacy.
3. Impaired nutrition: less than body requirements related to decreased intake.
4. Deficient cardiac output related to the potential for dysrhythmias.

The first thing you should notice in this question stem is the phrase “highest priority.” This alerts you that there may be more than one answer that could be considered correct.

Step 1. Look at the answer choices.

Both physical and psychosocial interventions are included. Apply the Maslow strategy.

Step 2. Eliminate all answer choices that involve psychosocial concerns.

It is easy to see that body image disturbance, answer choice (1), is a psychosocial concern. The same is true of answer choice (2), self-esteem disturbance. Answer choices (3) and (4) are physiological. You have now eliminated all but two answer choices.

Step 3. Ask yourself whether the remaining answer choices make sense.

Answer choice (3), “Impaired nutrition: less than body requirements related to decreased intake,” does make sense. Remember, the client has anorexia nervosa, is 5'4" (162 cm) tall and weighs 82 lb (37 kg). Answer choice (4), “Deficient cardiac output related to the potential for dysrhythmias,” also makes sense. Dysrhythmias are a concern for a client with severe hypokalemia, which often occurs with anorexia nervosa.

You still have work to do.

Step 4. Can you apply the ABCs? Yes.

Deficient cardiac output is a higher priority than altered nutrition. One answer choice remains: (4).

When you first read this question, you probably identified each of the answer choices as appropriate for a client with anorexia nervosa. Only one nursing diagnosis can be the highest priority. Using strategies involving Maslow and the ABCs will enable you to choose the correct answer on your NCLEX-PN® exam.



## Strategy Two: Nursing Process (Data Collection Versus Implementation)

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A second strategy that will assist you in establishing priorities involves the data collection and implementation steps of the nursing process. As a practical/vocational nursing student, you have been drilled so that you can recite the steps of the nursing process in your sleep—data collection, planning, implementation, and evaluation. In practical/vocational nursing school, you did have some test questions about the nursing process, but you probably did not use the nursing process to assist you in selecting a correct answer on an exam. On the NCLEX-PN<sup>®</sup> exam, you will be given a clinical situation and asked to establish priorities. The possible answer choices will include both the correct data collection action and implementation for this clinical situation. How do you choose the correct answer when both the correct mode of data collection and implementation are given? Think about these two steps of the nursing process.

Data collection is the process of establishing a data profile about the client and his or her health problems. The nurse obtains subjective and objective data in a number of ways: talking to clients, observing clients and/or significant others, taking a health history, evaluating laboratory results, and collaborating with other members of the health care team.

Once you collect the data, you compare it to the client's baseline or normal values. On the NCLEX-PN® exam, the client's baseline may not be given, but as a practical/vocational nursing student you have acquired a body of knowledge. On this exam, you are expected to compare the client information you are given to the "normal" values learned from your nursing textbooks.

Data collection is the first step of the nursing process and takes priority over all other steps. It is essential that you complete the data collection phase of the nursing process before you implement nursing activities. This is a common mistake made by NCLEX-PN® exam takers: don't implement before you collect data. For example, when performing cardiopulmonary resuscitation (CPR), if you don't access the airway before performing mouth-to-mouth resuscitation, your actions may be harmful!

Implementation is the care you provide to your clients. Nursing interventions may be independent, dependent, and interdependent. Independent nursing interventions are generally not within the scope of the LPN/LVN's nursing practice. However, the LPN/LVN can follow established care plans, standards of care, and established protocols. For example, the LPN/LVN can instruct a client to turn, cough, and deep-breathe after surgery. Dependent interventions are based on the written orders of a primary health care provider. On the NCLEX-PN® exam, you should assume that you have an order for all dependent interventions that are included in the answer choices.

This may be a different way of thinking from the way you were taught in practical/vocational nursing school. Many students select an answer on a nursing school test (that is later counted wrong) because the intervention

requires a primary health care provider's order. Everyone walks away from the test review muttering "trick question." It is important for you to remember that there are no trick questions on the NCLEX-PN<sup>®</sup> exam. You should base your answer on an understanding that you have a primary health care provider's order for any nursing intervention described.

Interdependent interventions are shared with the RN and other members of the health care team. For instance, nutrition education would be directed and supervised by the RN and may be shared with the LPN/LVN and the dietician. Chest physiotherapy may be directed and supervised by the RN and shared with a respiratory therapist and an LPN/LVN.

The following strategy, utilizing the data collection and implementation phases of the nursing process, will assist you in selecting correct answers to questions that ask you to identify priorities.

Step 1. Read the answer choices to establish a pattern.

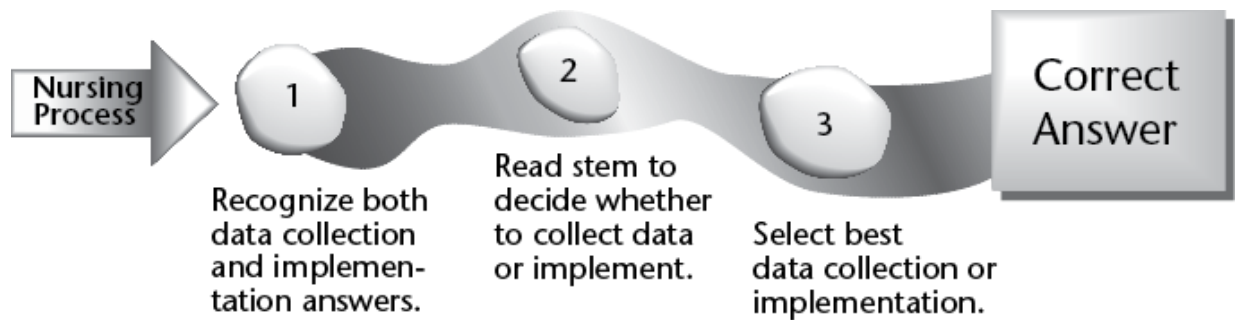
If the answer choices are a mix of data collection/validation and implementation, use the Nursing Process (Data Collection vs. Implementation) strategy.

Step 2. Refer to the question.

Determine whether you should be collecting data or implementing.

Step 3. Eliminate answer choices, and then choose the best answer.

If after Step 2 you find that, for example, it is a data collection question, eliminate any answers that clearly focus on implementation. Then choose the best data collection answer.



Try this strategy on the following question.

The LPN/LVN is caring for a client who underwent abdominal surgery 6 hours ago. Which of the following actions by the LPN/LVN is **most** important?

1. Have the client use a pillow to splint the incision.
2. Instruct the client how to safely get out of bed.
3. Reinforce the dry dressing to provide more padding.
4. Turn the client to check for bleeding underneath the client.

THE REWORDED QUESTION: What nursing priority should the LPN/LVN identify in this scenario? What are the risks for a client after abdominal surgery?



Step 1. Read the answer choices to establish a pattern.

There is one data collection answer, (4), and three implementation answers, (1), (2), and (3). You can use the Nursing Process (Data Collection vs. Implementation) strategy.

Step 2. Refer to the question to determine if you should be collecting data or implementing care.

You know that bleeding is a risk for all surgical abdominal wounds. According to the nursing process, you should collect data first.

Step 3. Eliminate answer choices, and then choose the best answer.

Eliminate answers (1), (2), and (3), which are implementation answers. You are left with only one answer choice, (4). Clients with abdominal surgical wounds often find their most comfortable position lying on their backs in bed. Fluid, namely blood, flows via gravity to dependent areas. A cursory look at the top of the dressing may reveal no drainage; however, when the client is rolled to the side, a pool of blood could be noted if the wound is hemorrhaging. Even if this had not occurred to you, you are still able to correctly answer this question using the data collection versus implementation strategy.

Let's look at another question.

A child biking to school hit the curb and then fell, injuring the leg. The LPN/LVN was called and found the

child alert and conscious, but in severe pain with a possible right femur fracture. Which of the following is the **first** action that the LPN/LVN should take?

1. Immobilize the affected limb with a splint and ask the client not to move.
2. Collect data of the circumstances surrounding the accident.
3. Place the client in semi-Fowler's position to facilitate breathing.
4. Check pedal pulse and blanching sign in both legs and compare the findings.

The words “first action” tell you that this is a “priority” question.

THE REWORDED QUESTION: What is the highest priority for a fractured femur?

Step 1. Read the answer choices to establish a pattern.

The answer choices are a mix of data collection and implementation, so use the Nursing Process (Data Collection vs. Implementation) strategy.

Step 2. Determine whether you should be collecting data or implementing.

According to the question, the LPN/LVN has determined that the child has a possible fracture. This implies that the LPN/LVN has completed the data-collection step. It is now time to implement.

Step 3. Eliminate answer choices, and then choose the best answer.

Eliminate answers (2) and (4) because they involve data collection. This leaves you with choices (1) and (3). Which takes priority: immobilizing the affected limb, or placing the client in a semi-Fowler's position to facilitate breathing? The question does not indicate any respiratory distress. The correct answer is (1), immobilize the affected limb.

Some students will choose an answer involving the ABCs without thinking it through. Students, beware. Use the ABCs to establish priorities, but make sure that the answer is appropriate to the situation. In this question, breathing was mentioned in one of the answer choices. If you thought of the ABCs immediately without looking at the context of the question, you would have answered this question incorrectly.

Look at this question in another form.

A child biking to school hit the curb, and then fell. The child tells the LPN/LVN, "I think my leg is broken."  
Which of the following is the **first** action the LPN/LVN should take?

1. Immobilize the affected limb with a splint and ask the client not to move.
2. Collect data of the circumstances surrounding the accident.
3. Place the client in semi-Fowler's position to facilitate breathing.
4. Check the appearance of the client's leg.

Step 1. Determine whether you should be collecting data or implementing. In this question, the client has stated, "My leg is broken." This statement is not the LPN/LVN's data collection. This alerts the LPN/LVN that there is a problem, and the LPN/LVN should begin the steps of the nursing process. The first step is data collection.

Step 2. Eliminate answers (1) and (3). These are implementations.

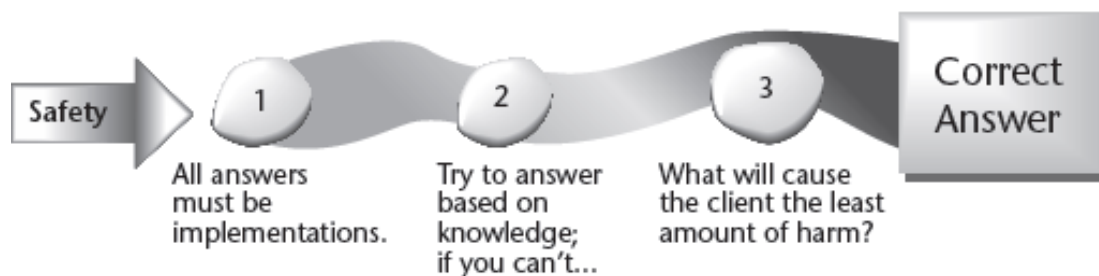
Step 3. What takes priority? Examination of the leg takes priority over investigation into what happened to cause the accident. The correct answer is (4).

## Strategy Three: Safety

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LPN/LVNs have the primary responsibility of ensuring the safety of clients. This includes clients in health care facilities, in the home, at work, and in the community. Safety includes meeting basic needs (oxygen, food, fluids, etc.), reducing hazards that cause injury to clients (accidents, obstacles in the home), and decreasing the transmission of pathogens (immunizations, sanitation).

Remember that the NCLEX-PN® exam is a test of minimum competency to determine that you are able to practice safe and effective nursing care. Always think safety when selecting correct answers on the exam. When answering questions about procedures, this strategy will help you to establish priorities.



Step 1. Are all the answer choices implementations? If so, use the Safety strategy illustrated above.

Step 2. Can you answer the question based on your knowledge? If not, continue to Step 3.

Step 3. Ask yourself, “What will cause my client the least amount of harm?” and choose the best answer.

Apply this strategy to the following question.

A pediatric client undergoes a tonsillectomy for treatment of chronic tonsillitis unresponsive to antibiotic therapy. After surgery, the client is brought to the clinical unit. Which of the following actions should the LPN/LVN include in the client’s plan of care?

1. Institute measures to minimize crying.
2. Perform postural drainage every 2 hours.
3. Cough and deep-breathe hourly.
4. Provide ice cream as tolerated.

THE REWORDED QUESTION: What should you do after a tonsillectomy?

Step 1. Are all the answer choices implementations?

Yes.

Step 2. Can you answer the question based on your knowledge of a tonsillectomy?

If not, continue to Step 3.

Step 3. Ask yourself, “What will cause the client the least amount of harm?”

Answer choice (1), minimizing crying, will help prevent bleeding. Keep in consideration. Answer choice (2), postural drainage, may cause bleeding. Eliminate. Coughing and deep-breathing (3) may cause bleeding. Eliminate. Providing ice cream (4) may cause the child to clear the throat, causing bleeding. Eliminate. The correct answer is (1). The nurse must prevent postoperative hemorrhage, a complication seen after this type of surgery. Crying would irritate the child’s throat and increase the chance of hemorrhage.

Let’s try another question.

The LPN/LVN doubts the accuracy of a medication order in the client's medication administration record (MAR). Which of the following actions should the LPN/LVN take **first**?

1. Compare order in medication administration record to order in medical record.
2. Contact the prescribing primary health care provider to question the order.
3. Consult with the hospital pharmacist about the accuracy of the medication order.
4. Look up medication in nursing drug book and compare information to medication order.

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THE REWORDED QUESTION: What should you do if you think the medication administration record (MAR) is incorrect?

Step 1. Are all the answers implementations?

Yes.

Step 2. Ask yourself the question, “What will protect my client the most?”

Comparing the MAR with the original primary health care provider’s order would certainly provide clarification regarding the questioned medication. Leave this choice for consideration.

Calling the prescribing primary health care provider would certainly help clarify the order, but this should not be the first step. Eliminate.

Consulting the hospital pharmacist can shed light on a medication, but the LPN/LVN first needs to know what the original order said. Eliminate.

Looking up the medication in a nursing drug book is a good idea, but will this step help the LPN/LVN if the original order was incorrectly transcribed in the MAR? Eliminate.

Only choice (1) is left for consideration and is the correct answer. The NCLEX-PN® test makers want to know what decision you are going to make to protect your client, not what decision the primary health care provider will make.

Let’s look at another question.

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A client admitted with a diagnosis of dementia attempts several times to remove the nasogastric tube. The LPN/LVN receives an order for wrist restraints. Which of the following actions by the LPN/LVN is **most** appropriate?

1. Attach the ties of the wrist restraints to the client's bed frame.
2. Perform daily range-of-motion exercises to the restrained extremities.
3. Remove the restraints when the client is out of bed in a wheelchair.
4. Explain restraint need to the family only, because the client is confused.

THE REWORDED QUESTION: “What is the safest way to apply restraints?”

Step 1. Are all answers implementations?

Yes.

Step 2. Can you answer this based on your knowledge?

If not, proceed to Step 3.

Step 3. Ask yourself, “What will cause the least amount of harm to the client?”

(1) Attaching the restraint ties to the client's bed frame will not harm the client. Retain this answer.

(2) Performing daily range-of-motion exercises will not harm the client. However, they should be performed more frequently. Retain this answer.

(3) Removing the restraints when the client is out of bed in a wheelchair will be harmful to the client. Restraints should not be removed when the client is unattended. Eliminate.

(4) Explaining the need for restraints only to the family can cause harm to the client. Restraints can increase the confusion or combativeness of the client. Even though confused, the client needs to receive an explanation. Eliminate.

You are now considering answer choices (1) and (2). What will cause the least amount of harm to the client—attaching the ties of the restraint to the bed frame or performing daily range-of-motion exercises to the extremities? Range-of-motion exercises should be performed every 2 to 4 hours to prevent loss of joint mobility. Eliminate (2). The correct answer is (1). Attaching the ties of the restraints to the bed frame will allow the nurse to raise and lower the side rail without injury to the client.

Priority questions are an important component of the NCLEX-PN® exam. To help you select correct answers, think:

- Maslow
- The Nursing Process
- Safety

Answer the following three questions using the appropriate priority strategy. The explanations follow the questions.

## Question 1

The LPN/LVN is caring for a client with a diagnosis of stroke. The LPN/LVN is feeding the client in a chair when the client suddenly begins to choke. Which of the following actions should the LPN/LVN take **first**?

1. Check the client for breathlessness.
2. Leave the client in the chair and apply vigorous abdominal or chest thrusts.
3. Ask the client, “Are you choking?”
4. Return the client to the bed and apply vigorous abdominal or chest thrusts.

## Question 2

A client with a history of bipolar disorder is admitted to the psychiatric hospital. The client was found by the police attempting to climb onto the wing of a plane at the airport. A family member reports that the client has not eaten or slept in 2 days, and suspects the client has stopped taking lithium. On admission, the LPN/LVN

should place the **highest** priority on which of the following client care needs?

1. Reinforcing to the client the importance of taking lithium as prescribed.
2. Providing the client with a safe environment with few distractions.
3. Arranging for food and rest for the client.
4. Setting limits on the client's behavior.

### Question 3

The primary health care provider orders a nasogastric (NG) tube inserted and connected to low intermittent suction for a client with an intestinal obstruction. Two hours after NG tube insertion, the client vomits 200 mL. While irrigating the NG tube, the LPN/LVN notes resistance. Which of the following actions should the LPN/LVN take **first**?

1. Replace the NG tube with a larger one.
2. Turn the client on the left side.
3. Implement continuous NG tube suction.
4. Continue NG tube irrigation.

Let's see if you were able to correctly determine which strategy you should use to determine priorities.

## Question 1

The answer choices include both data collection and implementations. Use the Nursing Process strategy to select the correct answer.

Step 1. Read the answer choices to establish a pattern.

Choices (1) and (3) are data collection; choices (2) and (4) are implementations.

Step 2. Refer to the question to determine whether you should be collecting data or implementing. According to the situation, the client has begun to choke. This alerts the nurse that there is a problem. The first step of the nursing process is data collection.

Step 3. Eliminate answer choices, and then choose the best answer.

Eliminate answer choices (2) and (4) because they are implementations. Now choose the best answer from the remaining answer choices, (1) and (3).

What takes priority—checking for breathlessness or collecting data by asking the client, “Are you choking?” Inability to speak or cough indicates airway obstruction. Breathlessness should be checked only in an unconscious client. The correct answer is (3).

## Question 2

Look at the answer choices. They include both physiological and psychosocial interventions. Apply the Maslow strategy.

Step 1. Look at the answer choices and identify which are physiological—choices (2) and (3)—and which are psychosocial—choices (1) and (4).

Step 2. Eliminate all psychosocial answer choices—(1) and (4).

Step 3. Ask yourself if the remaining answer choices make sense. Choice (2), providing the client with a safe environment, does make sense. Retain this answer. Choice (3), arranging for food and rest, also makes sense. Retain this answer.

Step 4. Can you apply the ABCs to the remaining answer choices? No; neither choice refers to airway, breathing, or circulation. Since the ABCs don't apply, ask yourself "What is the highest priority—providing for a safe environment, or providing for food and rest?" According to Maslow, food and rest take highest priority. The correct answer is (3).

## Question 3

This question is about a procedure: What should the nurse do when resistance is met while irrigating an NG tube? If you are unsure about a procedure, think safety.

Step 1. Read the answer choices to establish a pattern. Are all the answer choices implementations? Yes.

Step 2. Can you answer the question based on your knowledge? If not, continue to Step 3.

Step 3. Ask yourself, “What will cause the client the least amount of harm?”

Replacing the NG tube with a larger one could harm the client by damaging the mucosa. Eliminate.

Turning the client to the left side would not hurt the client. Retain this answer choice.

Changing the suction from intermittent to continuous is never done because it will erode the mucosa. Eliminate.

Continuing the irrigation when there is resistance might be harmful. Never force an irrigation. Eliminate.

The correct answer is (2). The tip of the tube may be against the stomach wall. Repositioning the client might allow the tip to lie unobstructed in the stomach.

Using the critical thinking strategies outlined in this chapter will help you unlock the secrets of correctly answering priority questions.

# Chapter Quiz

1. The LPN/LVN is caring for a client several hours after application of a right lower extremity cast. The client reports, "My right toes feel funny." What is the first action the LPN/LVN should take?
  - (A) Elevate right leg on pillow.
  - (B) Administer an analgesic.
  - (C) Reassure the client that tingling is normal.
  - (D) Compare capillary refill of right and left toes.
  
2. The LPN/LVN is assisting a client with ambulation when the client begins to fall. What is the most appropriate action for the LPN/LVN to take?
  - (A) Grasp the client under the arms, bend at the waist, and assist the client to the floor.
  - (B) Place feet close together, place arms under the client's axillae, and slide the client to the floor.
  - (C) Place arms around the client's waist and assist the client to the closest chair or bed.
  - (D) Place feet wide apart, push the pelvis forward, and slide the client down one leg.



3. The LPN/LVN is observing that a client's radial pulse is now 56 beats per minute. It was 72 beats per minute 4 hours ago. What is the most important action for the LPN/LVN to take?

- (A) Check the oxygen saturation level.
- (B) Begin oxygen at 2 L/minute by nasal cannula.
- (C) Obtain the client's blood pressure.
- (D) Palpate bilateral pedal pulse strength.

4. A client reports to the LPN/LVN, "I just started to feel short of breath." The client has normal saline solution infusing at a rate of 75 mL/hour through a peripherally inserted central catheter (PICC). What is the first action the LPN/LVN should take?

- (A) Obtain client's blood pressure and apical heart rate.
- (B) Reassure client that shortness of breath will improve.
- (C) Observe the insertion site of the PICC.
- (D) Elevate the head of the bed 90 degrees.

5. The LPN/LVN at the urology clinic is obtaining a health history from an elderly male client who reports back pain during urination and difficulty starting and stopping the urine flow. Which of the following goals is most important for the LPN/LVN to include in the client's plan of care?

- (A) Pain medication.
- (B) Antibiotic administration.
- (C) Physical therapy.
- (D) Laboratory testing.

6. The LPN/LVN is caring for the client whose vaginal delivery resulted in a stillborn infant. Which of the following actions by the nurse is the most important?

- (A) Be available to the client to listen to expressions of grief.
- (B) Provide the client with appropriate fluid replacement.
- (C) Check client's perineal pad frequently for excess bleeding.
- (D) Tell client about measures to cope with severe uterine pain.

7. The LPN/LVN is observing the client who has just eaten lunch having an episode of projectile vomiting. Which of the following actions should the nurse take first?

- (A) Give client an emesis basin.
- (B) Obtain the client's vital signs.
- (C) Contact client's primary health care provider.
- (D) Record the food intake from client's meal tray.

8. A frail client is admitted to the hospital for dehydration. The client is incontinent of urine and stool. The LPN/LVN should give which of the following nursing diagnoses the highest priority?

- (A) Body image disturbance related to immobility.
- (B) Self-esteem disturbance related to loss of independence.
- (C) Impaired nutrition: intake less than body fluid requirements.
- (D) Risk for impaired skin integrity related to incontinence.

9. The primary health care provider has ordered a condom catheter for a male client. Which of the following is the most important question the LPN/LVN should ask the client before carrying out this order?

- (A) "Do you have a latex allergy?"
- (B) "Do you have a history of urinary tract infections?"
- (C) "Do you have a history of frequent nocturia?"
- (D) "Have you been circumcised?"

10. The client is about to be discharged home with a portable oxygen delivery system. The LPN/LVN knows that which of the following education topics is most important for the client's family?

- (A) Correct use of prescribed nebulizers and inhalers.
- (B) Prohibition of flame or heat sources in the same room.
- (C) Relaxation techniques, such as visualization or meditation.
- (D) Maintenance of adequate hydration and nutrition.



## Answers and Explanations

## CHAPTER QUIZ

### 1. The Answer is 4

The LPN/LVN is caring for a client several hours after application of a right lower extremity cast. The client reports, “My right toes feel funny.” What is the first action the LPN/LVN should take?

Strategy: Read the question to identify the topic: possible decrease in circulation after cast application. The client is at risk for injury from compromised circulation.

Next, read the answer choices. They are a mix of physiological and psychosocial, so apply Maslow: Rule out the psychosocial answers, and review the remaining options for sense and ABCs.

Category: Data Collection/Physiological Integrity/Basic Care and Comfort

What is the outcome of leg elevation? Circulation to the right leg, foot, and toes will decrease. Is this desired? No.

This is not an appropriate first action. If an analgesic is administered, it may alter some of the observations that indicate circulatory compromise.

Reassuring the client is psychosocial. Physical answers are the priority; eliminate.

**CORRECT:** By comparing capillary refill of both right and left toes, the LPN/LVN observes circulation in the casted extremity. Prolonged capillary refill may indicate decreased blood flow to the right foot and toes.

## 2. The Answer is 4

The LPN/LVN is assisting a client with ambulation when the client begins to fall. What is the most appropriate action for the LPN/LVN to take?

Strategy: Read the question and answers to identify the topic. All answer choices are implementations. The topic is client safety.

Next, consider the outcome of each answer choice: Which best promotes client safety? Also consider appropriate body mechanics while assisting the client and protecting yourself from injury.

Category: Implementation/Safe and Effective Care Environment/Safety and Infection Control

Bending at the waist is an example of body mechanics that increase risk of injury to the LPN/LVN. Grasping the client under the arms does not provide the greatest stability while assisting the client.

This action increases the risk of injury to the LPN/LVN. The LPN/LVN should place feet wide apart to increase safety.

This action increases the risk of injury to the client. It is more important to assist the client to a safe position than to place the client on a chair or bed.

**CORRECT:** The outcome of this action is desired. The positioning of the feet (wide) and pelvis (forward) ensures stability, and sliding the client down the leg decreases the risk of injury to the client.

## 3. The Answer is 3

The LPN/LVN observes that a client's radial pulse is now 56 beats per minute. It was 72 beats per minute 4 hours ago. What is the most important action for the LPN/LVN to take?

Strategy: Think about what happens when a client's heart rate decreases significantly: Cardiac output may decrease, leading to decreased perfusion of vital organs. Determine if data collection or implementation is more important.

Category: Planning/Physiological Integrity/Physiological Adaptation

Oxygen saturation levels indicate the amount of oxygen attached to the red blood cells. Are oxygen saturation levels affected by cardiac output? No. They are affected by altered respiratory function.

Eliminate.

Giving supplemental oxygen may be an appropriate action, but is it the priority action? More data is needed.

CORRECT: If heart rate decreases, cardiac output and blood pressure decrease, decreasing blood flow to the brain and other vital organs and increasing the risk of organ damage. Select this answer.

Observing bilateral pulse strength may be an appropriate action, but is it the most important? No. The priority is to gather data related to blood flow to vital organs. Eliminate.

#### 4. The Answer is 4

A client reports to the LPN/LVN, "I just started to feel short of breath." The client has normal saline infusing at a rate of 75 mL/hour through a peripherally inserted central catheter (PICC) line. What is the first action the LPN/LVN should take?

Strategy: The answer choices are a mix of physiological and psychosocial, so apply Maslow: Rule out the psychosocial answers, and review the remaining options for sense and ABCs.

Category: Implementation/Physiological Integrity/Physiological Adaptation

Obtaining the client's blood pressure may be an appropriate action, but is it the first action? The client reports shortness of breath, and immediate action is needed.

Reassuring the client is a psychosocial answer; eliminate.

What is the outcome of this answer? Observing the site of the PICC may show if infiltration or thrombophlebitis is present.

CORRECT: What happens when the client is in the upright position? Chest expansion increases and respiratory status improves.

#### 5. The Answer is 4

The LPN/LVN at the urology clinic is obtaining a health history from an elderly male client who reports back pain during urination and difficulty starting and stopping the urine flow. Which of the following goals is most important for the LPN/LVN to include in the client's plan of care?

Strategy: Think about the consequences of each goal in light of the client's problem with his urinary system.

Category: Data Collection/Safe and Effective Care Environment/Coordinated Care



The client will not benefit from pain medication, because it will not address the cause of the discomfort during urination.

Without laboratory test results, it is not known if the client has an infection, so antibiotic therapy is not warranted.

Physical therapy is not indicated for urological conditions.

CORRECT: The client will have a urinalysis and a serum prostate-specific antigen (PSA) testing to help diagnose the condition.

#### 6. The Answer is 3

The LPN/LVN is caring for the client whose vaginal delivery resulted in a stillborn infant. Which of the following actions by the nurse is the most important?

Strategy: “Most important” indicates a priority. Maslow’s hierarchy of needs prioritizes the need for physiological survival.

Category: Implementation/Safe and Effective Care  
Environment/Coordinated Care

Although emotional support is important, it is psychosocial; physiological needs take precedence.

There is no evidence of dehydration in this client.

CORRECT: The nurse should check the client’s perineal pad frequently for excess bleeding. Circulation is the third of the ABCs.

Checking for hemorrhaging, a physiological complication, is more important than educating about pain relief.

#### 7. The Answer is 2

The LPN/LVN is observing the client who has just eaten lunch having an episode of projectile vomiting. Which of the following actions should the nurse take first?

Strategy: “First action” indicates a priority. Determine if data collection or implementation is more important.

Category: Planning/Safe and Effective Care Environment/Coordinated Care

An emesis basin is inadequate to contain further projectile vomiting.

CORRECT: Data collection about the client’s status is needed before action taking action.

The primary health care provider will inquire about the client's vital signs.

Recent food intake is unlikely to have caused projectile vomiting.

8. The Answer is 3

A frail client is admitted to the hospital for dehydration. The client is incontinent of urine and stool. The LPN/LVN should give which of the following nursing diagnoses the highest priority?

Strategy: Think about the basic needs of every client. Remember the ABCs.

Category: Planning/Safe and Effective Care Environment/Coordinated Care

Body image disturbance is a psychosocial concern. Physiological needs take priority.

Self-esteem disturbance is also a psychosocial concern.

CORRECT: The client's dehydration impairs normal circulation.

Although this physiological risk is present, circulation takes precedence over skin injury; remember the ABCs.

9. The Answer is 1

The primary health care provider has ordered a condom catheter for a male client. Which of the following is the most important question the LPN/LVN should ask the client before carrying out this order?

Strategy: Determine why you would ask each question.

Category: Data Collection/Safe and Effective Care  
Environment/Coordinated Care

CORRECT: A latex allergy would preclude the use of some condom catheters.

Research has shown that condom catheters cause fewer urinary tract infections than indwelling urinary catheters.

After the primary health care provider has ordered the condom catheter, the client's voiding pattern is not an issue.

Circumcision is not a contraindication to use of a condom catheter.

10. The Answer is 2

The client is about to be discharged home with a portable oxygen delivery system. The LPN/LVN knows that which of the following

education topics is most important for the client's family?

Strategy: "Most important" indicates a priority. Consider the outcome of each answer choice.

Category: Implementation/Safe and Effective Care  
Environment/Coordinated Care

Treatment education is important, but basic physical safety takes priority.

CORRECT: Flame or any source of heat, such as a lit cigarette, candle, or space heater, could cause a fatal fire in the presence of an oxygen delivery system.

The risk of fire must be taught before addressing any concern about relaxation.

Education about basic physiological needs is important, but warning about the risk of a fatal fire takes priority.



## CHAPTER 6

# STRATEGIES FOR COORDINATION OF CARE QUESTIONS

The delivery of health care in the United States is an ever more integrated system, utilizing the skills of physicians; advanced practice nurses (e.g., nurse practitioners [NPs]); registered nurses (RNs); licensed practical nurses (LPNs), also called licensed vocational nurses (LVNs); and unlicensed assistive personnel (UAPs) such as certified nursing assistants (CNAs), nursing assistants, and home health aides. Each position carries its own duties and responsibilities, but coordination of all the members of the health care team is essential for the delivery of optimal care to the client. This chapter discusses the coordination of care, especially as it pertains to LPN/LVNs.

Many health care settings, including hospitals, clinics, and physician and NP private practices, are staffed by RNs and LPN/LVNs, in addition to NPs and UAPs. In most situations, it is the responsibility of the RN to coordinate the care ordered by the physician and to assign specific duties to LPN/LVNs and NPs according to the level of knowledge and skills they possess and their legal scope of practice as set by state regulations. (In those situations in which NPs are present, the task of assigning duties to RNs and/or LPN/LVNs may fall to them.) The individual state boards of nursing set the

standards that, for the most part, vary little and comply with the National Council of State Boards of Nursing (NCSBN).

In this chapter, we'll discuss the responsibilities and duties that the LPN/LVN is qualified to perform. We'll also review, in general, the scope of practice of LPN/LVNs and RNs, as well as the roles of NPs and UAPs. You'll see questions interspersed in the discussion to help make the general guidelines concrete in specific cases.



# Licensed Practical Nurse/Licensed Vocational Nurse (LPN/LVN)

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An LPN/LVN has specific education and skills and is licensed to work in a health care setting under the supervision of a primary health care provider, dentist, podiatrist, or, most commonly, an RN (or NP). The role of the LPN/LVN is defined by the theoretical and clinical content taught in practical/vocational nursing programs within each state and approved by the individual state board of nursing/regulatory body.

## Scope of Practice/Role of the LPN/LVN

Each state has a specific scope of practice for LPN/LVNs under which they may practice. Under the supervision of an RN, LPN/LVNs provide care for which they are specifically trained. They care for stable clients and perform procedures with predictable outcomes.

The LPN/LVN is often the bedside nurse, providing care to stable clients. LPN/LVNs monitor vital signs, collect data, monitor intake and output, check blood glucose levels, apply dressings, insert and care for indwelling urinary catheters as well as nasogastric tubes, empty Jackson-Pratt (JP) drains, administer enemas, maintain oxygen protocols, and administer

prescribed medications. Some states restrict the administration of intravenous (IV) medications and solutions by LPN/LVNs.

Many of the duties of an LPN/LVN involve data collection. The LPN/LVN is taught to distinguish normal from abnormal findings when observing clients (for example, normal versus abnormal heart sounds) and to recognize changes from previously recorded data (for example, a sudden drop in blood pressure). The data, especially abnormal findings and changes in clinical findings, are reported to an RN (or primary health care provider) to provide the necessary information for client care.

The LPN/LVN does not perform an initial client assessment: that is the responsibility of the supervising RN (or primary health care provider). However, after the initial assessment has been made and a plan of care initiated, the LPN/LVN may collect data, reporting the findings to the supervising RN. In general, the LPN/LVN carries out the plan of care developed by the RN.

LPN/LVNs may also be involved in reinforcing client teaching, such as educating pregnant women about childbirth and the care of an infant. LPN/LVNs may also practice “telephone nursing,” using protocols developed by a primary health care provider. The protocols state what information to request of a caller, what to tell the caller, and how to direct the caller to proceed, depending on the condition for which he or she is calling.

In some states, LPN/LVNs, with additional education and certification, may have an expanded role in IV therapy and hemodialysis under the supervision of an on-site RN. The specific situations, medications, and



procedures that the LPN/LVN may perform are strictly limited and outlined by state regulations. However, in most states, LPN/LVNs are responsible for assessing IV infusions and administration sites on their assigned clients, but they do not initiate, manage, or deliver IV therapy. LPN/LVNs also cannot pronounce a client dead in most states.

Also, in some states, LPN/LVNs assume the care of specific clients utilizing an overall plan of care developed by the RN. This situation most often arises in cases where rapid changes are not expected in the client's condition. The LPN/LVN may be assigned to monitor the client regularly while the RN is available for consultation and periodic monitoring. In long-term care facilities, the LPN/LVN may assume the "charge nurse" role with consultation of an in-house supervising RN.

Specifically, LPN/LVNs:

- Provide emotional and physical comfort for the client.
- Carry out the client plan of care initiated by the RN.
- Observe a client's signs and symptoms and report any changes to the supervising RN.
- Perform nursing procedures for which the LPN/LVN has the necessary skills and training, such as routine bedside care, data collection, dressing changes, indwelling urinary catheter insertion and care, respiratory care and suctioning, ostomy care, and non-IV medication administration.
- May help RNs in the care of seriously ill clients in intensive care units or in delivery rooms or neonatal units.
- Assist with the rehabilitation of clients according to the client's plan of care.

Let's look at a question that focuses on the scope of practice and roles of the LPN/LVN.

Which of the following client-care activities would it be appropriate for an LPN/LVN to perform?

1. Obtain detailed 24-hour diet recall from client newly admitted with a suspected eating disorder.
2. Obtain catheterized urine sample from client with a fever and slight lower abdominal discomfort.
3. Collect data for an adolescent client experiencing an acute asthma attack.
4. Care for a school-age client with a new tracheostomy for laryngotracheal bronchitis.

Strategy: Remember that LPN/LVNs perform activities concerning stable clients with predictable outcomes.

A 24-hour diet history is an important part of the initial assessment of a client with suspected anorexia nervosa or other eating disorder. It helps guide the treatment plan. RNs, not LPN/LVNs, provide the initial clinical assessment. Eliminate this answer choice.

LPN/LVNs routinely collect catheterized urine samples. It is a routine procedure that the LPN/LVN is qualified to perform. Keep this answer choice for consideration.

An adolescent client experiencing an acute asthma attack is unstable. The care of such an unstable client with an uncertain outcome

would not normally be assigned to an LPN/LVN. Eliminate this answer choice.

A school-age client with a new tracheostomy for laryngotracheal bronchitis is unstable and, therefore, needs the assessment and care of an RN. Eliminate this answer choice.

The correct answer is (2).



# Registered Nurse (RN)

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The RN is responsible for the quality of nursing care, including the assessment of nursing needs, the planning of nursing care and its implementation, the monitoring and evaluation of the plan, and the supervision of LPN/LVNs.

## Scope of Practice/Roles of the RN

The RN is responsible and accountable for making decisions based on his or her knowledge, competency, experience, and use of nursing processes; compliance with state laws and regulations; practice within the scope of practice for RNs in his or her specific state; and awareness of the scope of practice for LPN/LVNs. The decisions made must afford quality nursing care to clients and may include the assignment of specific duties to other qualified personnel (e.g., LPN/LVNs) and the appraisal of the care given by these assigned caregivers. Assignment of specific duties is essential if proper care is to be provided.

Specific responsibilities of the RN include:

- Assessing, evaluating, and making nursing judgments. These tasks cannot be delegated or assigned to LPN/LVNs or other members of the health care team.

- Assigning specific tasks to LPN/LVNs and other personnel for stable clients with predictable outcomes. If the client is unstable or the outcome of a specific procedure is unknown, the RN should personally monitor the client.
- Assigning standard activities involving unchanging procedures, such as feeding and bathing a stable client, to the appropriate member of the health care team. Feeding, bathing, and dressing a stable client are usually assigned to a UAP, while bedside monitoring following the client's individual plan of care is usually assigned to an LPN/LVN.

## Coordination with LPN/LVNs

RNs and LPN/LVNs have a unique and delicate relationship within the health care setting. Although the RN assigns the LPN/LVN specific care or tasks for a specific client, the RN is ultimately responsible for the work of the LPN/LVN and how it affects the client. At the same time, the RN must recognize that LPN/LVNs are licensed by their state board of nursing/regulatory body and have completed a program of study that qualifies them to perform certain tasks and to have certain responsibilities. The LPN/LVN provides client care based on his or her own license.

The degree of supervision the RN exercises over the LPN/LVN is based on an evaluation of the condition of the client; of the education, skill, and training of the LPN/LVN; and of the nature of the tasks being assigned to the LPN/LVN. The supervision of the RN, physically present in the health care facility, may be a direct continuing presence or an intermittent observation and direction.

The next question may help you understand how this works in practice.

The LPN/LVN should question which of the following assignments?

1. Obtain a stool sample for occult blood.
2. Provide nutrition information to a new mother.
3. Adjust the position of a client who has just received medication for pain relief.
4. Assess a client who has just returned to the room following abdominal surgery.

Obtaining a stool sample is a routine procedure and thus can be performed by an LPN/LVN. Eliminate this answer choice.

Providing nutrition information to a new mother is within the scope of practice of an LPN/LVN. Eliminate this answer choice.

Positioning a client is within the scope of practice of an LPN/LVN. Eliminate this answer choice.

An LPN/LVN cannot perform the initial assessment of a client following surgery. This is outside the scope of practice of an LPN/LVN.

The correct answer is (4).

# Roles of Other Members of the Health Care Team

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Let's briefly mention the roles of other possible members of the health care team. As an LPN/LVN, you may find yourself working with any or all of the following professionals:

- Nurse practitioners (NPs) are RNs with advanced education and training; in most states, NPs can diagnose illnesses and prescribe medications. If present in the health care setting, the NP would supervise the RN and the LPN/LVN, or just the RN who, in turn, would assign duties to the LPN/LVN.
- Unlicensed assistive personnel (UAPs) include both certified nursing assistants (CNAs), who are regulated by the state boards of nursing, and nursing assistive personnel (NAPs) including nursing assistants and home health aides. UAPs aid RNs and LPN/LVNs by performing routine duties, such as feeding and bathing stable clients. Obtaining specific supplies requested by the LPN/LVN or RN for the care of a client would also be part of the duties of a UAP.

Based on what you have learned about coordination of care and the duties of each member of the health care team, answer the next question.

The nursing unit contains an RN, an LPN/LVN, and a UAP. Which of the following client-care activities would be **most** appropriate for the LPN/LVN to perform?

1. Obtain vital signs for a client who was admitted with several fractures.
2. Monitor a client who had an ovarian tumor removed 2 days ago for signs of infection.
3. Teach a client recently diagnosed with diabetes mellitus to perform an insulin injection.
4. Bathe and change the clothes of a client who is recovering from an appendectomy.

A client admitted with several fractures is not in a stable condition and needs assessment, part of which is obtaining vital signs. An RN needs to provide the initial assessment. Eliminate this answer choice.

LPN/LVNs are trained to observe a client for changes in signs and symptoms, such as an increase in temperature or other signs of infection, and to report the changes to the supervising RN. Keep this answer choice for consideration.

Teaching a client with newly diagnosed diabetes mellitus to perform injection techniques is not within the scope of practice of an LPN/LVN. An RN performs this type of teaching. Eliminate this answer choice.

While an LPN/LVN could be asked to help in this situation, a UAP is more likely to be asked to perform this duty. An LPN/LVN is licensed, with specific education and training, so his or her services could probably be better used in another way. Eliminate this answer choice.



The correct answer is (2). Although the LPN/LVN could be asked to perform the duties listed in answer choice (4), that assignment would not be the most appropriate.

The following is another question to help you understand coordination of care.

Which of the following client-care assignments is **best** for an LPN/LVN?

1. Help a client who is recovering from surgery with bathing, linen change, and ambulation to the bathroom.
2. Perform a head-to-toe assessment, including breath sounds, for a client admitted yesterday with pneumonia.
3. Assess a newly admitted client with a high fever and productive cough.
4. Change the dressing for a stasis ulcer in a client with diabetes.

A UAP would normally be the person to help bathe and ambulate a client as well as change bed linen. Eliminate this answer choice.

LPN/LVNs routinely collect head-to-toe data, including breath sounds, for stable clients. As this client is recently admitted, the RN should do the assessment. Eliminate this answer choice.

RNs provide initial clinical assessment for newly admitted clients.  
Eliminate this answer choice.

LPN/LVNs are qualified to change dressings in stable clients. This is the best client-care assignment.

The correct answer is (4).

# Coordination of Care Questions

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Here are a few more questions to test your understanding of coordination of care.

Which of the following client-care activities should be assigned to an LPN/LVN?

1. Auscultate breath sounds and collect sputum sample from a client with a history of respiratory problems.
2. Assess a client just returned from surgery to correct a spinal deformity.
3. Provide emergency care to a client who suffered cardiac arrhythmia during exercise.
4. Care for an unconscious client who is bleeding profusely from a stab wound.

An LPN/LVN can auscultate breath sounds, report the findings to the RN, and collect a sputum sample for analysis. Keep this answer choice for consideration.

Immediate postoperative assessment is the responsibility of the RN, especially in such a serious case as spinal surgery. The RN may subsequently ask the LPN/LVN to monitor the client, requesting that he be alert for specific signs/symptoms. Eliminate this answer choice.

LPN/LVNs are not usually employed in emergency departments, but if they are, they help the RN (or primary health care provider), following specific instructions. Eliminate this answer choice.

An unconscious client who is bleeding profusely from a stab wound is in unstable condition and has an unpredictable outcome. An LPN/LVN does not routinely provide care for such an unstable client. Eliminate this answer choice.

The correct answer is (1).

Which of the following client-care activities should be assigned to an LPN/LVN?

1. Assess a new admission who is reporting of severe abdominal pain.
2. Review the education on birthing methods provided to a pregnant client.
3. Provide bedside care for an infant client with a fever and obvious discomfort.
4. Change the dressing of a client who has undergone a partial mastectomy.

Obtaining a complete assessment on a newly admitted client is the responsibility of an RN. Eliminate this answer choice.

While an LPN/LVN may provide reinforce teaching to a pregnant client on birthing methods, only an RN can evaluate the effectiveness of the teaching. Eliminate this answer choice.

Fever in an infant is a serious concern that requires careful assessment and frequent monitoring, tasks that should be performed by an RN. Eliminate this answer choice.

LPN/LVNs are qualified to look for changes in the appearance of a wound and to change dressings as part of their overall monitoring of a stable client recovering from surgery. Keep this answer choice for consideration.

The correct answer is (4).

As stated earlier, health care in the United States, with its ever more sophisticated tests, techniques, and treatments, in combination with budget constraints and frequent understaffing, requires the coordination of care among licensed and unlicensed members of the health care team. Each member of the team must be called upon to contribute specific knowledge and skills so that an integrated personalized plan of care for each client is implemented. It is very important to utilize the specific education, training, and skills of an LPN/LVN, who provides bedside care for stable clients under the supervision of an RN. Doing so frees the RN to perform assessment, nursing diagnosis, development and implementation of a plan of care, and evaluation. At the same time, the assignment of time-consuming routine tasks, such as bathing and feeding stable clients, to an NAP allows the licensed members of the team to maximize the use of their skills.

An understanding of the coordination of care is essential for an LPN/LVN and for other members of the health care team. The efficient use of each member's specific knowledge and skills allows the pursuit of a common goal—the best care possible for the client.

## Chapter Quiz

1. The LPN/LVN is part of the care team in a medical-surgical unit. The LPN/LVN would expect to perform which of the following client-care activities? Select all that apply.
  - (A) Educate the presurgical client about clean-catch urine sample procedures.
  - (B) Assess the client who has just returned to the room following bladder surgery.
  - (C) Monitor the client who had a tonsillectomy the day before.
  - (D) Call a code on the client found to be unresponsive.
  - (E) Review the effectiveness of client education about nebulizer use.
  - (F) Perform the initial dressing change on the client recovering from gallbladder surgery.
  
2. The LPN/LVN is caring for clients in the acute medical-surgical unit. The LPN/LVN should question which assignment?

- (A) Monitor urine output of the client diagnosed with acute kidney injury.
- (B) Perform nasotracheal suctioning for a client 4 days after a stroke.
- (C) Provide tracheostomy care for the client with a cuffed tracheostomy tube.
- (D) Receive hand-off report for the client being transferred from the emergency department.

3. Which task is most appropriate for the unlicensed assistive personnel (UAP) to perform?

- (A) Reset a client's IV infusion pump when the alarm sounds.
- (B) Change a peripheral IV catheter insertion site dressing.
- (C) Observe pH of gastric secretions from enteral feeding tube.
- (D) Assist with the insertion of a small-bore enteral tube.

4. The LPN/LVN is caring for clients in a pediatric urgent care clinic. The supervisor indicates that the LPN/LVN will float to an adult postoperative care unit. Which is the most appropriate statement the LPN/LVN should make?



- (A) “I can’t go to another unit. I don’t have the proper skills to care for postoperative adult clients.”
- (B) “I will have to work under the supervision of another LPN/LVN while on the postoperative care unit.”
- (C) “I will need to inform the postoperative unit supervisor that my experience has been pediatric care.”
- (D) “I am only qualified to check vital signs and document intake and output on the postoperative care unit.”

5. The LPN/LVN is floating to several units in the community hospital. Which of the following client-care activities is best for the LPN/LVN?

- (A) Assisting a postsurgical client with ambulation to the bathroom.
- (B) Checking with family members about the effectiveness of discharge teaching.
- (C) Instructing newly admitted client about diagnostic test preparation.
- (D) Changing the purulent dressing of a client with a stage 4 pressure injury.

6. A rehabilitation unit is staffed by an RN, 2 LPN/LVNs, and a UAP. The UAP has just called in sick. Which of the following client-care assignments would be appropriate for the LPN/LVNs? Select all that apply.

- (A) Assess the newly admitted client with hip dysplasia.
- (B) Bathe the client who is recovering from back surgery.
- (C) Take vital signs of the client receiving IV antibiotics for a bone infection.
- (D) Listen for breath sounds in the client with a history of chronic asthma.
- (E) Show the postsurgical client how to use crutches.
- (F) Teach the client recently diagnosed with arthritis how to self-administer a weekly injection.

7. The LPN/LVN is caring for clients in the medical-surgical unit of the acute care facility. Which assignment is most appropriate for the LPN/LVN?

- (A) Observe a client who reports “tightness in the chest”; a 12-lead ECG is ordered.
- (B) Teach a client newly diagnosed with type 2 diabetes; the client is prescribed glyburide.
- (C) Change sterile dressing on the leg of a client 3 days after peripheral vascular surgery.
- (D) Instruct a client diagnosed with heart failure about exercise and home medications.

8. The LPN/LVN is working in the oncology unit at the pediatric hospital. Which of the following assignments, if made by the team leader, should be questioned by the LPN/LVN?

- (A) Providing information on chemotherapy to a parent.
- (B) Transporting a newly admitted client to the radiology department.
- (C) Finding a comfortable position for a client with post-treatment nausea.
- (D) Responding to a call light from a concerned parent.

9. The LPN/LVN is working the night shift in the urgent care clinic. Which of the following assignments, if made by the team leader, should be questioned by the LPN/LVN?

- (A) Teaching the client with abdominal pain how to obtain a stool sample for occult blood.
- (B) Collecting sputum sample from client with a persistent cough.
- (C) Giving a tetanus vaccine injection to the client bleeding after a bicycle accident.
- (D) Monitoring the status of the newborn with fever and rash.

10. The LPN/LVN is working in the endocrinology clinic. The LPN/LVN knows that which of the following client-care activities should be performed only by an RN?

- (A) Taking the medical history of the client with diabetic neuropathy.
- (B) Using a glucometer to test the blood glucose level of the newly diagnosed diabetic.
- (C) Teaching the newly diagnosed diabetic to perform an insulin injection.
- (D) Administering an insulin injection to the newly diagnosed diabetic.



## Answers and Explanations

## CHAPTER QUIZ

1. The Answer is 1, 3, 4, and 6

The LPN/LVN is part of the care team in a medical-surgical unit. The LPN/LVN could expect to perform which of the following client-care activities? Select all that apply.

Strategy: Think about the skill level involved in each client-care activity.

Category: Implementation/Safe and Effective Care  
Environment/Coordinated Care

CORRECT: The LPN/LVN can educate pre- and postsurgical clients about laboratory test sample collection procedures.

Performing the initial assessment of a client following surgery is outside the scope of LPN/LVN practice. An RN would perform this task.

CORRECT: LPN/LVNs are trained to observe stable clients for changes indicating complications. One day after a tonsillectomy, the client would be considered in stable condition.

CORRECT: LPN/LVNs can call a code on an unresponsive client.

The LPN/LVN can provide medication instruction, but only an RN can evaluate the effectiveness of the teaching.

CORRECT: LPN/LVNs are qualified to examine a surgical incision for problems as part of their overall monitoring of stable postsurgical clients.

2. The Answer is 4

The LPN/LVN is caring for clients in the acute medical-surgical unit. The LPN/LVN should question which assignment?

Strategy: Remember that LPN/LVNs perform activities concerning stable clients with predictable outcomes. LPN/LVNs can reinforce teaching after RN has done initial teaching. Be careful! You are looking for an incorrect action.

Category: Evaluation/Safe and Effective Care Environment/Coordinated Care

Monitoring urine output is within LPN/LVN scope of practice. LPN/LVNs can monitor urine output and report observations to the RN. Eliminate.

Providing nasotracheal suctioning for this client is within LPN/LVN scope of practice. LPN/LVNs can do nasotracheal suctioning in stable clients with predictable outcomes. Eliminate.

Providing tracheostomy care for this client is within LPN/LVN scope of practice. LPN/LVNs can do tracheostomy care in stable clients with predictable outcomes. Eliminate.

CORRECT: Receiving hand-off report is not within LPN/LVN scope of practice. Also, a client that is being admitted to the client care area from the emergency department is unstable and requires assessment and evaluation by an RN. LPN/LVNs care for stable clients with predictable outcomes.

3. The Answer is 4

Which task is most appropriate for the unlicensed assistive personnel (UAP) to perform?

Strategy: Remember that UAPs can assist clients with activities of daily living and perform standard, unchanging procedures.

Category: Evaluation/Safe and Effective Care Environment/Coordinated Care

Resetting a client's IV infusion pump alarm requires assessment and evaluation; it is not within UAP scope of practice. Eliminate.

Changing a peripheral IV catheter insertion site dressing is not within UAP scope of practice. Eliminate.

Observing the pH of gastric secretions requires assessment and evaluation; it is not within UAP scope of practice. Eliminate.

CORRECT: Assisting with the insertion of a small-bore enteral tube is within UAP scope of practice. UAPs may assist with procedures.

#### 4. The Answer is 3

The LPN/LVN is caring for clients in a pediatric urgent care clinic. The supervisor indicates that the LPN/LVN will float to an adult postoperative care unit. Which is the most appropriate statement the LPN/LVN should make?

Strategy: Remember that skills are transferable during the care of clients. Float nurses should know and be able to perform core competencies in the new unit to meet legal obligations as an LPN/LVN.

Category: Implementation/Safe and Effective Care Environment/Coordinated Care



Skills are transferable. The LPN/LVN should be familiar with and prepared to perform core competencies. Eliminate.

Rules of delegation should be followed. The LPN/LVN should inform the supervisor of previous experience and request an orientation. Eliminate.

CORRECT: The LPN/LVN should inform the supervisor of previous experience and request an orientation.

Float nurses should know and be able to perform core competencies on the new unit to meet legal obligations as an LPN/LVN. Eliminate.

#### 5. The Answer is 3

An LPN/LVN is floating to several units in the community hospital. Which of the following client-care activities is best for an LPN/LVN?

Strategy: “Best” indicates that discrimination is required to answer the question.

Category: Implementation/Safe and Effective Care Environment/Coordinated Care

An unlicensed assistive personnel (UAP) would be an appropriate member of staff to assist a postsurgical client to the bathroom.

Evaluating the effectiveness of discharge teaching is within the scope of RN practice, not LPN/LVN duties.

CORRECT: LPN/LVNs are trained to provide client education and physical preparation for diagnostic tests.

LPN/LVNs are qualified to change dressings in stable clients. A client with a stage 4 pressure injury is not considered stable.

6. The Answer is 2, 3, 4, and 5

A rehabilitation unit is staffed by an RN, 2 LPN/LVNs, and a UAP. The UAP has just called in sick. Which of the following client-care assignments would be appropriate for the LPN/LVNs? Select all that apply.

Strategy: For each answer choice, determine the skill level involved in completing the specific task.

Category: Planning/Safe and Effective Care Environment/Coordinated Care

RNs undertake clinical assessment of newly admitted clients.

CORRECT: An LPN/LVN could appropriately perform this task, more often assigned to a UAP, in the absence of this member of staff.

CORRECT: An LPN/LVN is trained to take accurate vital signs and report significant deviations from normal.

CORRECT: An LPN/LVN can listen for breath sounds and report the findings to the RN.

CORRECT: An LPN/LVN could appropriately perform this task, more often assigned to a UAP, in the absence of this member of staff.

An RN performs this type of teaching, which is outside the scope of LPN/LVN practice.

7. The Answer is 3

The LPN/LVN is caring for clients in the medical-surgical unit of the acute care facility. Which assignment is most appropriate for the LPN/LVN?

Strategy: Remember that LPN/LVNs perform activities concerning stable clients with predictable outcomes. LPN/LVNs can reinforce teaching

after an RN has done the initial teaching.

Category: Planning/Safe and Effective Care Environment/Coordinated Care

This client is not stable and requires assessment and evaluation by an RN.

The LPN/LVN can reinforce initial teaching done by an RN.

CORRECT: The LPN/LVN can administer prescribed therapies such as dressings.

The LPN/LVN can reinforce initial teaching done by an RN.

8. The Answer is 1

The LPN/LVN is working in the oncology unit at the pediatric hospital. Which of the following assignments, if made by the team leader, should be questioned by the LPN/LVN?

Strategy: “Should be questioned” signals you to look for an outlier. Identify the assignment that is beyond the scope of practice of the LPN/LVN.

Category: Planning/Safe and Effective Care Environment/Coordinated Care

CORRECT: The RN is the team member who would communicate information about chemotherapy.

Although transportation is often assigned to unlicensed assistive personnel (UAPs), an LPN/LVN would not need to question this task.

LPN/LVNs are knowledgeable about positioning options.

LPN/LVNs routinely answer call lights.

9. The Answer is 4

The LPN/LVN is working the night shift in the urgent care clinic. Which of the following assignments, if made by the team leader, should be questioned by the LPN/LVN?

Strategy: “Should be questioned” signals you to look for an outlier. Identify the assignment that is beyond the scope of practice of the LPN/LVN.

Category: Planning/Safe and Effective Care Environment/Coordinated Care

An LPN/LVN can instruct a client about obtaining stool samples.

An LPN/LVN can collect a sputum sample.

An LPN/LVN can administer a tetanus vaccination.

CORRECT: Fever and rash in a newborn indicate the newborn’s condition is unstable and could deteriorate. The monitoring should be performed by an RN.

10. The Answer is 3

The LPN/LVN is working in the endocrinology clinic. The LPN/LVN knows that which of the following client-care activities should be performed only by an RN?

Strategy: Look at each answer choice in terms of the appropriate scope of practice. You are looking for an answer that is outside that scope.

Category: Implementation/Safe and Effective Care  
Environment/Coordinated Care

LPN/LVNs are trained to take medical histories.

LPN/LVNs are trained to use glucometers to obtain accurate blood glucose readings.

CORRECT: Teaching a newly diagnosed diabetic to perform insulin injections is not within the scope of LPN/LVN practice. An RN performs this type of teaching.

LPN/LVNs are trained in insulin injection techniques.



## CHAPTER 7

# STRATEGIES FOR POSITIONING QUESTIONS

Because many illnesses affect body alignment and mobility, you must be able to safely care for these clients in order to be an effective LPN/LVN. These topics are also important on the NCLEX-PN® exam. The successful test taker must correctly answer questions about impaired mobility and positioning.

Immobility occurs when a client is unable to move about freely and independently. To answer questions on positioning, you need to know the hazards of immobility, normal anatomy and physiology, and the terminology for positioning.

Many graduate LPN/LVNs are not comfortable answering these questions because:

- They don't understand the "whys" of positioning.
- They don't know the terminology.
- They have difficulty imagining the various positions.

If you have difficulty answering positioning questions, the following strategy will assist you in selecting the correct answer.



Step 1. Decide if the position for the client is designed to prevent something or promote something.

Step 2. Identify what it is you are trying to prevent or promote.

Step 3. Think about anatomy, physiology, and pathophysiology (“A&P”).

Step 4. Which position best accomplishes what you are trying to prevent or promote?

Does this sound a little confusing? Hang in there. Let’s walk through a question using this strategy.

Immediately after a percutaneous liver biopsy, the LPN/LVN should place the client in which of the following positions?

1. Supine.
2. Right side-lying.
3. Left side-lying.
4. Semi-Fowler’s.

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Before you read the answers, let's go through the four steps.

Step 1. By positioning the client after a liver biopsy, are you trying to prevent something or promote something? Think about what you know about a liver biopsy. You position a client after this procedure to prevent something.

Step 2. What are you trying to prevent? The most serious and important complication after a percutaneous liver biopsy is hemorrhage.

Step 3. Think about the principles of A&P. What do you do to prevent hemorrhage? You apply pressure. Where would you apply pressure? On the liver. Where is the liver? On the right side of the abdomen under the ribs.

Step 4. How should the client be positioned to prevent hemorrhage from the liver, which is on the right side of the body? Look at your answer choices.

Supine. If you lay the client flat on his back, no pressure will be applied to the right side. Eliminate.

Right side-lying. If you lay the client in a right side-lying position, will pressure be applied to the right side? Yes. Keep it in for consideration.

Left side-lying. No pressure is applied to the right side. Eliminate.

Semi-Fowler's. If you lay the client on the back with head partially elevated, no pressure is applied to the right side. Eliminate.

The correct answer is (2). Some students select (3) because they don't know normal anatomy and physiology. Some students select (4) because



semi-Fowler's position is used for a lot of reasons.

# Things to Remember

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- Even if you didn't memorize what position to use before, during, and after a procedure, think about the question for a moment. You can figure out what position is needed.
- You cannot figure out the correct position if you do not know what the terms (such as supine or Fowler's) mean.
- You cannot figure out a correct position if you do not know anatomy and physiology. If you think the liver is on the left side of the body, you are in trouble!
- You cannot figure out a correct position if you do not know what you are trying to accomplish. If you couldn't remember that a complication after a liver biopsy is hemorrhage, you will simply be taking a random guess at the correct answer.
- If you think in images, you should form a mental image of each position. Picture yourself placing the client in each position, and then see if the position makes sense.

Let's try another question using the strategies for positioning.

An angiogram is scheduled for a client with decreased circulation in the right leg. After the angiogram, the

LPN/LVN should place the client in which of the following positions?

1. Semi-Fowler's with right leg bent at the knee.
2. Side-lying with a pillow between the knees.
3. Supine with the right leg extended.
4. High Fowler's with right leg elevated.

Let's go through the steps.

Step 1. By positioning the client after an angiogram, are you trying to prevent something or promote something? You are trying to promote something.

Step 2. What are you trying to promote? Adequate circulation of the right leg.

Step 3. Think about the principles of A&P. What promotes adequate circulation in the right leg? Keeping the leg at or below the level of the heart so blood flow is not constricted.

Step 4. How will the client be positioned after an angiography to prevent constriction of vessels and keep the right leg at or below the level of the heart? Look at the answer choices.

Semi-Fowler's with the right leg bent at the knee. The head of the bed is elevated 30–45 degrees in this position. The leg is lower than the

heart. If the right leg is bent at the knee, this could constrict arterial blood flow. Eliminate.

Side-lying with a pillow between the knees. Use of a pillow in this position could create pressure points in the right leg. You don't want the knees bent. Eliminate.

Supine with leg extended. In this position, the leg is at the level of the heart. Circulation will not be constricted because the leg is straight. Keep this answer in for consideration.

High Fowler's with right leg elevated. The head of the bed is elevated 60–90 degrees in this position. Elevating the leg promotes venous return. Eliminate.

The correct answer is (3). The client is on bed rest for 8–12 hours in a supine position after an angiogram.

If you didn't know the specific positioning needed after an angiogram, you could apply your knowledge to select the correct answer by just thinking about it.

Let's look at another question.

The LPN/LVN is caring for a client after a lumbar laminectomy. Which of the following statements **best** describes the method of turning a client following a lumbar laminectomy?

1. The head of the bed is elevated 30 degrees; the client locks the knees when turning.
2. A pillow is placed between the client's legs; the body is turned as a unit.
3. The client straightens the back and grasps the side rail on the opposite side of the bed.
4. The head of the bed is flat; the client bends the knees and rolls to the side.

This question isn't about positioning after a procedure. It asks how to turn the client after surgery.

Step 1. When turning the client after a laminectomy, are you trying to prevent or promote something? Promote.

Step 2. What are you trying to promote? A straight back. The client can't bend or twist the torso.

Step 3. Think about the principles of anatomy, physiology, and pathophysiology (A&P). A laminectomy is removal of one or more vertebral laminae. After a laminectomy, the back should be kept straight.

Step 4. How should the client be turned in order to keep the back straight?

If the head of the bed is elevated 30 degrees, the back will not be straight. Eliminate.

If a pillow is placed between the legs and the body is rolled as a unit, the client's back will be kept straight. Keep in for consideration.

If the client grabs the opposite side rail, the client's torso will twist. The back will not be straight even though the client straightened the back before turning and twisting. Eliminate.

If the head of the bed is flat, the client's back will be straight. If the client bends the knees and rolls to the side, the back will not be kept straight. Eliminate.

The correct answer is (2). That is a textbook description of log-rolling. But if you didn't recall log-rolling, you were able to select the correct answer by thoughtfully considering each answer choice.

Sometimes a positioning question will be difficult to identify, such as in the following example.

The LPN/LVN is caring for a client after an appendectomy. The client continues to report discomfort to the nurse shortly after receiving an analgesic. Which of the following measures by the LPN/LVN would be **most** appropriate?

1. Notify the primary health care provider
2. Place the client in Fowler's position.
3. Massage the client's abdomen.
4. Provide the client with reading material.

As you can see, not all of the answer choices involve positioning. How should you approach this question?

First, reword the question so that you know what to focus on in the answer choices. The question really being asked is, “What should the LPN/LVN do to help this client with pain relief?” Let’s look at the answer choices.

Notifying the primary health care provider, as you know, is almost never the right answer. See if another answer choice is more appropriate.

Fowler’s position. Why change this client’s position? To promote pain relief. Will Fowler’s position decrease the client’s pain? Yes, by relieving pressure on the client’s abdomen. This answer is a possibility.

Massaging the client's abdomen will increase the client’s pain. Eliminate.

Providing the client with reading materials might distract the client from discomfort, but this is not an appropriate intervention for a client in pain. Eliminate.

The correct answer is (2).

Positioning is an important part of the NCLEX-PN® exam. You must be able to answer these questions correctly in order to prove your competence. If you use the strategies just discussed, you will be thinking about nursing principles and you will select correct answers!

# Essential Positions to Know for the NCLEX-PN® Exam

POSITION	THERAPEUTIC FUNCTION
Flat (supine)	Avoids hip flexion, which can compress arterial flow
Dorsal recumbent	Supine with knees flexed; more comfortable
Side lateral	Allows drainage of oral secretions
Side with leg bent (Sims')	Allows drainage of oral secretions; used for rectal exam
Head elevated (Fowler's) <ul style="list-style-type: none"><li>• High Fowler's: 60–90 degrees</li><li>• Fowler's: 45–60 degrees</li><li>• Semi-Fowler's: 30–45 degrees</li><li>• Low Fowler's: 15–30 degrees</li></ul>	Increases venous return; allows maximal lung expansion
Feet and legs elevated	Increases blood return to heart
Feet elevated and head lowered (Trendelenburg)	Used to insert central venous pressure (CVP) line, or for treatment of umbilical cord compression



POSITION	THERAPEUTIC FUNCTION
Feet elevated 20 degrees, knees straight, trunk flat, and head slightly elevated (modified Trendelenburg)	Increases venous return; used for shock
Elevation of extremity	Increases venous return; decreases blood volume to extremity
Flat on back, thighs flexed, legs abducted (lithotomy)	Increases vaginal opening for examination
Prone	Promotes extension of hip joint; not well tolerated by persons with respiratory or cardiovascular difficulties
Knee-chest	Provides maximal visualization of rectal area

# Chapter Quiz

1. The LPN/LVN is caring for a client diagnosed 6 months ago with a 6th thoracic (T6) spinal cord injury. The client reports a “throbbing headache,” and the client’s face, neck, and upper chest are flushed and diaphoretic. Which action should the LPN/LVN take first?
  - (A) Loosen the client's upper body clothing.
  - (B) Check the client for fecal impaction.
  - (C) Remove the indwelling urinary catheter.
  - (D) Sit the client in an upright position.
  
2. The LPN/LVN is assisting with the care of a client diagnosed 2 weeks ago with a right-sided stroke. When assisting the client with meals, it is most important for the LPN/LVN to take which action?
  - (A) Encourage the client to swallow each bite of food 4 times.
  - (B) Assist the client to use a straw to drink fluids with the meal.
  - (C) Instruct the client to sit in a chair for 30 minutes after the meal.
  - (D) Provide 8 oz (240 mL) of milk with every meal and at bedtime.
  
3. The LPN/LVN is assisting with the care of a client diagnosed with a 4th cervical (C4) complete spinal cord injury. Which observation

most concerns the LPN/LVN?

- (A) The unlicensed assistive personnel (UAP) positions the client in a 30-degree side-lying position.
- (B) The client watches television with the head of the bed elevated at a 45-degree angle.
- (C) The unlicensed assistive personnel (UAP) uses warm water and a gentle soap for bathing.
- (D) The client lightly rubs the skin with a bath towel after bathing to ensure dryness.

4. The LPN/LVN is assisting with the care of a client 48 hours after a right total hip arthroplasty. Which observation requires an intervention by the LPN/LVN?

- (A) The client is positioned in a high Fowler's position during meal times.
- (B) The right and left legs are slightly abducted when client is supine.
- (C) The head of the bed is elevated 50 degrees during morning oral care.
- (D) The unlicensed assistive personnel (UAP) places a pillow between client's legs before turning client.

5. The LPN/LVN is preparing the female client for a vaginal examination. The client is positioned to best increase the vaginal opening for examination. Which of the following features would this position include? Select all that apply.

- (A) Soft pillow under head.
- (B) Back flat on exam table.
- (C) Knees straight.
- (D) Elbows flexed.
- (E) Thighs abducted.
- (F) Legs adducted.

6. The LPN/LVN in the long-term care facility is assisting the client with chronic obstructive pulmonary disease and varicose veins. Before breakfast is served, the LPN/LVN places the client in Fowler's position. Which of the following best describes why Fowler's position would be used in this client?

- (A) It straightens the neck, which allows client to swallow more effectively.
- (B) It pulls the diaphragm downward, which permits greater chest expansion.
- (C) It puts the back in a natural position, which relieves muscle tension.
- (D) It increases venous return, which improves the circulation to the legs.

7. The LPN/LVN is preparing the client with hemorrhoids for a rectal examination. Depending on the physical limitations of the client, the nurse should put the client in which of the following positions? Select all that apply.

- (A) Prone.
- (B) Supine.
- (C) Knee-chest.
- (D) Trendelenburg.
- (E) Sims'.
- (F) Fowler's.

8. The home-care LPN/LVN is visiting the frail client with type 2 diabetes, osteoporosis, and nighttime drooling. The client sleeps in the prone position. The nurse recognizes which of the following as an advantage of this position for the client? Select all that apply.

- (A) It allows full extension of the hip and knee joints.
- (B) It produces lordosis in most people.
- (C) It causes plantar flexion.
- (D) It keeps saliva drainage flowing from the mouth.
- (E) It promotes better breathing.
- (F) It prevents hypoglycemia.

9. The LPN/LVN in the postsurgical unit cares for the client immediately after an L4-L5 spinal fusion. The primary health care provider's order calls for the client to be turned every hour. Arrange the following steps in the order that the nurse should perform them. All options must be used.

- (A) Place the pillow between the client's legs.
- (B) Remove the pillow from under the client's head.
- (C) Perform hand hygiene.
- (D) Document the client's repositioning.
- (E) Firmly grasp the client's draw sheet with both hands.
- (F) Move the client's body as a unit.

10. The LPN/LVN is caring for the obstetrical client who is in active labor. Suddenly the fetus's umbilical cord can be seen protruding from the vagina. The LPN/LVN will immediately place the client in which of the following positions?

- (A) Trendelenburg.
- (B) Sims'.
- (C) Prone.
- (D) Semi-Fowler's.



## Answers and Explanations

## CHAPTER QUIZ

### 1. The Answer is 4

The LPN/LVN is caring for a client diagnosed 6 months ago with a 6th thoracic (T6) spinal cord injury. The client reports a “throbbing headache,” and the client’s face, neck, and upper chest are flushed and diaphoretic. Which action should the LPN/LVN take first?

Strategy: As you can see, not all the answers involve positioning. Read the question and answers to identify the topic, and note the level of the spinal cord injury. What complication of spinal cord injury do these symptoms describe? Autonomic dysreflexia is a potential complication when a client has a spinal cord injury of T6 or above. The topic is the first action to take when autonomic dysreflexia is suspected.

Autonomic dysreflexia is an emergency. Immediate action must be taken to prevent severe hypertension and a stroke. Think about which action will decrease blood pressure most quickly.

Category: Implementation/Physiological Integrity/Reduction of Risk Potential

Loosening the upper body clothing is an appropriate action when autonomic dysreflexia occurs, but is it the first action? Keep for consideration.

Checking for fecal impaction is an appropriate action, as fecal impaction may be a cause of autonomic dysreflexia. The impaction should be removed, but is it the first action? Keep for consideration.



Removing the indwelling urinary catheter is an appropriate action. Bladder distension may be a cause of autonomic dysreflexia. If the catheter is obstructed, it should be removed. Is this the first action? Keep for consideration.

CORRECT: What happens if you sit the client upright? The client's blood pressure will immediately decrease. Remember that autonomic dysreflexia is an emergency and immediate action must be taken to decrease blood pressure. This action will prevent a further increase in blood pressure. Select this answer.

## 2. The Answer is 3

The LPN/LVN is assisting with the care of a client diagnosed 2 weeks ago with a right-sided stroke. When assisting the client with meals, it is most important for the LPN/LVN to take which action?

Strategy: Identify the topic of the question: All answers relate to swallowing and eating. Recall that clients diagnosed with stroke often have difficulty swallowing and are at risk for aspiration. The question asks you to select the priority, or "Most important" action—preventing aspiration. Consider each answer choice and determine if the action will decrease the risk of aspiration.

Category: Implementation/Physiological Integrity/Physiological Adaptation

Swallowing each bite of food more than once will help clear the oropharynx and decreases the risk of aspiration. Is it necessary for the client to swallow each bite of food 4 times? No. Eliminate.

Use of a straw and drinking thin liquids both increase the risk of choking and aspiration. Thin liquids are more difficult to swallow. The risk of choking and aspiration is increased. Eliminate.

CORRECT: What happens when a client sits in an upright position after a meal? Gravity increases the passage of food into the stomach. Will this help prevent aspiration? Yes. Keep for consideration.

Milk and milk products increase production of saliva and make swallowing more difficult. The client is at greater risk for aspiration. Eliminate.

### 3. The Answer is 2

The LPN/LVN is assisting with the care of a client diagnosed with a 4th cervical (C4) complete spinal cord injury. Which observation most concerns the LPN/LVN?

Strategy: Read the question and answers to identify the topic: prevention of pressure injuries. Recall that clients diagnosed with a spinal cord injury are at risk for pressure injuries due to immobility, inability to detect sensation, and shearing force, which can damage the tissue. Next, consider each answer choice. Remember, you are looking for something that indicates a problem.

Category: Evaluation/Physiological Integrity/Physiological Adaptation

Does a 30-degree side-lying position indicate a problem? No. This position reduces the risk for pressure injury formation.

CORRECT: Does this indicate a problem? Yes. If a client sits at a 45-degree angle of elevation, there is shearing force on bony prominences. The risk of pressure injury formation is increased.

Does bathing with warm water and gentle soap indicate a problem? No. Gentle skin cleansing decreases the tissue irritation and damage that can lead to pressure injury formation. These agents are also less irritating to the skin than hot water and strong soap.

Does this indicate a problem? No. If light pressure is used when rubbing the skin with a bath towel, there is less risk of tissue irritation and damage.

#### 4. The Answer is 1

The LPN/LVN is assisting with the care of a client 48 hours after a right total hip arthroplasty. Which observation requires an intervention by the LPN/LVN?

Strategy: Identify the topic: appropriate positioning after a total hip arthroplasty. Recall the goals for clients after a total hip arthroplasty. One goal is to prevent subluxation (partial dislocation) or total dislocation of the prosthesis.

The question asks which answer requires an intervention. Review the answers and determine if each action is correct or incorrect. Be careful! You are looking for an incorrect action.

Category: Evaluation/Physiological Integrity/Physiological Adaptation

CORRECT: When a client is in high Fowler's position, the degree of elevation is 60–90 degrees. What is the effect of this position? It increases the risk of prosthesis dislocation. This action is incorrect.

What is the effect of slight abduction of the involved hip and leg? It decreases the risk of prosthesis dislocation. This is a desired

outcome.

Elevating the head 60 degrees or less does not increase the risk of prosthesis dislocation. (By contrast, if the head is elevated more than 60 degrees, the risk of subluxation and dislocation is increased.) This action is correct.

Placing a pillow between the legs while turning maintains slight abduction of the involved hip and leg. This action is correct.

5. The Answer is 2 and 5

The LPN/LVN is preparing the female client for a vaginal examination. The client is positioned to best increase the vaginal opening for examination. Which of the following features would this position include? Select all that apply.

Strategy: Visualize the client ready for the examination. Then consider each answer choice in turn.

Category: Planning/Reduction of Risk Potential

The pillow will bend the neck upward, causing discomfort.

CORRECT: The back remains flat on the examination table.

The client's feet will not fit into the stirrups if knees are straight.

Placement of the arms does not play a factor in this position.

CORRECT: The thighs are angled away from the trunk of the body (abduction).

The legs are not brought close to the trunk of the body (adduction).

6. The Answer is 2

The LPN/LVN in the long-term care facility is assisting the client with chronic obstructive pulmonary disease and varicose veins. Before breakfast is served, the LPN/LVN places the client in Fowler's position. Which of the following best describes why Fowler's position would be used in this client?

Strategy: "Best" indicates that discrimination is required to answer the question. Remember the ABCs.

Category: Implementation/Physiological Integrity/Basic Care and Comfort

A client in Fowler's position can use a pillow to moderately flex the neck. This would not impede, and might help, the client's swallowing ability.

CORRECT: Gravity pulls the diaphragm downward, increasing space for lung expansion. The client can breathe easier.

There is no "natural" back position.

Fowler's position promotes venous return; however, the reason this client is placed in Fowler's position is to increase chest expansion to help the client breathe.

#### 7. The Answer is 3 and 5

The LPN/LVN is preparing the client with hemorrhoids for a rectal examination. Depending on the physical limitations of the client, the nurse should put the client in which of the following positions? Select all that apply.

Strategy: Visualize the client ready for the examination. Then consider each answer choice.

Category: Planning/Reduction of Risk Potential

In the prone position, where the client lies on the abdomen, the rectal area cannot be readily accessed.

In the supine position, where the client lies on the back, there is no access to the rectal area.

CORRECT: The knee-chest position allows for visualization of the rectal area.

The Trendelenburg position has the client lying on the back, which gives no access to the rectal area.

CORRECT: In Sims' position, the client is lying on one side with the upper leg bent. This position allows access to the rectal area.

Fowler's position has the client lying on the back, which gives no access to the rectal area.

8. The Answer is 1 and 4

The home-care LPN/LVN is visiting the frail client with type 2 diabetes, osteoporosis, and nighttime drooling. The client sleeps in the prone position. The nurse recognizes which of the following as an advantage of this position for the client? Select all that apply.

Strategy: Remember this client's characteristics and the benefits of a prone position. Consider each answer choice keeping both facts in mind.

Category: Evaluation/Physiological Integrity/Basic Care and Comfort

CORRECT: Allowing full extension of the hip and knee joints is an advantage of the prone position.

Producing lordosis (inward curvature of the spine) is a disadvantage, because it puts strain on the client's back.

Causing plantar flexion is a disadvantage, because it overstretches the foot muscles.

CORRECT: Allowing saliva drainage to flow from the mouth is an advantage of the prone position.

The prone position does not promote better breathing. It inhibits chest expansion, which is a disadvantage.

The prone position has no effect on the client's blood glucose level; this is neither an advantage nor a disadvantage.

9. The Answer is 3, 2, 1, 5, 6, 4

The LPN/LVN in the postsurgical unit is caring for the client immediately after an L4-L5 spinal fusion. The primary health care provider's order calls for the client to be turned every hour. Arrange the following steps in the order that the nurse should perform them. All options must be used.

Strategy: Picture the client with a surgical wound in the lumbar region. It must not be distorted when moving the client.

Category: Implementation/Physiological Integrity/Basic Care and Comfort

Perform hand hygiene.

Remove the pillow from under the client's head.

Place the pillow between the client's legs.

Firmly grasp the client's draw sheet with both hands.

Move the client's body as a unit.

Document the client's repositioning.

10. The Answer is 1

The LPN/LVN is caring for the obstetrical client who is in active labor. Suddenly the fetus's umbilical cord can be seen protruding from the vagina. The LPN/LVN will immediately place the client in which of the following positions?

Strategy: Consider the outcome of placing the client in each position.

Category: Planning/Reduction of Risk Potential

CORRECT: The Trendelenburg position, with the client's head down, will shift the weight of the body upward, relieving pressure on the prolapsed cord.

Sims' position does not alter pressure on the prolapsed cord.

The prone position puts pressure on the client's abdominal area.

The Semi-Fowler's position puts pressure on the client's vaginal area.



## CHAPTER 8

# STRATEGIES FOR COMMUNICATION QUESTIONS

Communication is emphasized on the NCLEX-PN® exam because it is critical to your success as a beginning practitioner. Therapeutic communication means listening to and understanding the client while promoting clarification and insight. It enables the practical/vocational nurse to form a working relationship with both the client and the health care team, using both verbal and nonverbal communication. Remember that nonverbal communication is the most accurate reflection of attitude.

Therapeutic responses include the following.

RESPONSE	GOAL/PURPOSE
Using silence	Allows the client time to think and reflect; conveys acceptance. Allows the client to take the lead in conversation.
Using general leads or broad opening	Encourages the client to talk. Indicates your interest in the client. Allows the client to choose the subject.
Clarification	Encourages recall and details of a particular experience. Encourages description of feelings. Seeks explanation; pinpoints specifics.
Reflecting	Paraphrases what client says. Reflects on what client says, especially the feelings conveyed.



# Eliminate Answer Choices

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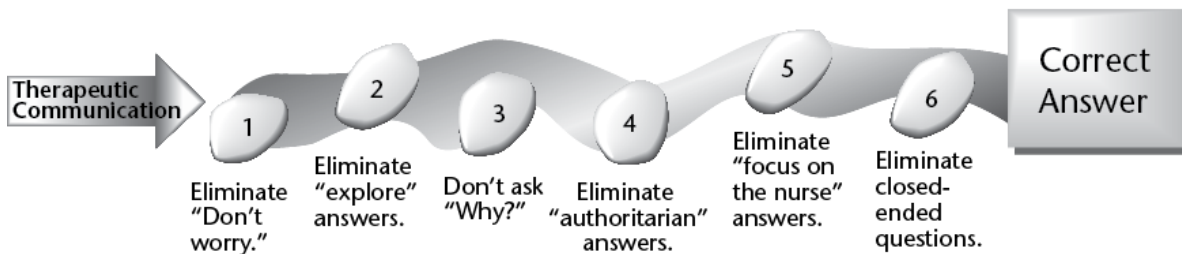
There are many questions on the NCLEX-PN® exam that require you to select the correct therapeutic communication response. As with other NCLEX-PN® exam questions, one of the biggest errors that students commit when trying to answer this type of question is to look for the correct answer. Remember, you are selecting the best answer from the four possible answers that you are given. To select the best answer, you must eliminate answer choices. Let's look at some of the different answer choices you can eliminate:

- “Don’t worry” answers: Eliminate answer choices that offer false reassurance. These type of responses discourage communication between the LPN/LVN and the client by not allowing the client to explore his or her own ideas and feelings. False reassurance also discounts what the client is feeling. Examples include:
  - “It is going to be OK.”
  - “Don’t worry. Your doctors will do everything necessary for your care.”
- “Let’s explore” answers: Another incorrect answer choice that many graduate practical/vocational nurses select is the choice that includes the word “explore.” On the NCLEX-PN® exam, avoid being a junior psychiatrist. It isn’t the practical/vocational nurse’s role to delve into the

reasons why the client is feeling a particular way. The client must be allowed to verbalize the fact that he or she is sad, angry, fearful, or overwhelmed. Examples include:

- “Let’s talk about why you didn’t take your medication.”
- “Tell me why you really injured yourself.”
- “Why” questions: Eliminate answer choices that include “why” questions: ones that seek reasons or justification. “Why” questions imply disapproval of the client, who may become defensive. A “why” question can come in many forms and need not always begin with “why.” Any response that puts the client on the defensive is nontherapeutic and therefore incorrect. Examples include:
  - “What makes you think that?”
  - “Why do you feel this way?”
- Authoritarian answers: Eliminate answer choices in which the LPN/LVN is telling the client what to do without regard to the client’s desires or feelings. Examples include:
  - Insisting that the client follow unit rules
  - Insisting that the client do what you command, immediately
- Nurse-focused answers: Eliminate answer choices in which the focus of the comment is on the LPN/LVN. Be careful, because these answer choices may sound very empathetic. The focus of your communication should always be on the client. Examples include:
  - “That happened to me once.”
  - “I know from experience this is hard for you.”

- Closed-ended questions: Eliminate answer choices that include closed-ended questions that can be answered with yes, no, or another monosyllabic response. Closed-ended questions discourage the client from sharing thoughts and feelings. Examples include:
  - “Are you feeling guilty about what happened?”
  - “How many children do you have?”



Eliminating these types of nontherapeutic responses that appear as answer choices is a very effective strategy when answering therapeutic communication questions. Don't simply look for the specific words that you see here; you may need to "translate" the answer choices into the above errors of therapeutic communication.

# Select the Correct Response

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So, how do you select the correct response? By choosing from the answer choices that are left! The correct response will usually contain one or both of the following elements:

- Gives correct information. Offering information encourages further communication from the client. Examples of giving correct information include:
  - “You are experiencing acute alcohol withdrawal; you may see and feel things that aren’t real.”
  - “There are many reasons for memory loss; tell me more about what you have noticed.”
- Is empathetic and reflects the client’s feelings. Empathy is the ability to perceive what another person experiences using that person’s frame of reference. Reflection communicates to the client that the LPN/LVN has heard and understands what the client is trying to communicate. When reflecting feelings, the LPN/LVN focuses on the feelings and not the content of what is said. Examples of empathetic, reflective statements include:
  - “I can see that you are frightened about being here.”
  - “You seem very upset. Tell me how you’re feeling.”

Let's practice with a few exam-style questions.

A client is admitted to the telemetry unit with a diagnosis of acute myocardial infarction. The client tells the LPN/LVN, "I'm scared, I think I'm going to die." Which of the following responses by the LPN/LVN would be **most** appropriate?

1. "Everything is going to be fine. We'll take good care of you."
2. "I know what you mean. I thought I was having a heart attack once."
3. "I'll call your primary health care provider so you can discuss it."
4. "It's normal to feel frightened. We're doing everything we can for you."

Step 1. Eliminate incorrect answer choices.

This is a "don't worry" response. There is no acknowledgment of the client's fears. Eliminate it.

The focus of this response is on the LPN/LVN, not the client. Eliminate it.

It is within the scope of nursing practice for the LPN/LVN to respond to the client's feelings. Don't pass the responsibility to the primary health care provider. Eliminate it.

This answer choice responds to feelings and provides information.  
Keep it in consideration.

Step 2. Select an answer from the remaining choices.

One answer was not eliminated: (4). This is the correct answer. The LPN/LVN both acknowledges that the client feels frightened and provides information.

Let's try another question.

A client is to undergo a breast biopsy. The client tells the LPN/LVN, "If I lose my breast, I know my husband will no longer find me attractive." Which of the following responses by the LPN/LVN would be **most** appropriate?

1. "You don't know if you are going to lose your breast. They are just doing the biopsy now."
2. "You should focus on your children right now. They are young and they need you."
3. "You seem to be concerned that your relationship with your husband might change."
4. "Why don't you wait and see what your husband's reaction is before you get upset."

Step 1. Eliminate answer choices.



This response gives false reassurance and discounts the client's feelings. Eliminate it.

This response is authoritarian: the LPN/LVN tells the client what to do. Eliminate it.

This response reflects the fears of the client. The response is open-ended and allows the client to express what she is feeling. Keep it in for consideration.

This response dismisses the feelings that the client is experiencing and gives advice. Eliminate it.

Step 2. Select an answer from the remaining choices.

You have eliminated three of the four answer choices. The correct answer is the only answer choice remaining, (3).

Let's look at one more question.

A client in the psychiatric unit asks the LPN/LVN, "Am I in a special radioactive shelter? When was it last checked for radioactivity?" Which of the following responses by the LPN/LVN would be **most** appropriate?

1. "This is a hospital, and we do not have a nuclear medicine department here."
2. "Don't worry, you're safe. There's no radioactivity here."
3. "I'm sure your safety is of concern to you, but this is a hospital."
4. "Please share with me what makes you think there is radioactivity here."

Step 1. Eliminate answer choices.

This response provides information. Leave it in for consideration.

This response offers false reassurances. Eliminate it.

This response reflects the client's concern about safety and provides information. Keep it in for consideration.

This response allows the client to verbalize, but you don't want to encourage a client with psychological problems to talk about hallucinations or delusions. Rather, you want your discussion to focus on the feelings that accompany them. Eliminate this choice.

Step 2. Select an answer from the remaining choices.

You have more than one possible answer choice: (1) and (3). Look for the answer choice that reflects feelings and gives information. The correct answer is (3).

Some things to remember about selecting correct answers to therapeutic communication questions are:

- No matter how confident you are about an answer choice, read all of the choices before selecting an answer.
- Even if you would never say any of the responses given in the answer choices, choose the “textbook” answer.
- When you first read the answer choices, don’t look for the correct answer. Always eliminate answer choices first.

If you follow the Kaplan strategies for therapeutic communication, you will be able to select the correct answers to this question type on the NCLEX-PN<sup>®</sup> exam.

## Chapter Quiz

1. The LPN/LVN is caring for the client in the pediatric unit. The client's parents, whom the nurse has not met, approach the nurse at the nursing station. Arrange the following steps in the order that the LPN/LVN should perform them. All options must be used.
  - (A) The nurse documents the significant parts of the conversation.
  - (B) The nurse brings the parents to a private area to talk.
  - (C) The nurse affirms the parents' ability to take care of their child at home.
  - (D) The nurse invites the parents to talk about their questions on home care.
  - (E) The nurse follows up with literature about home care instructions.
  - (F) The nurse and the parents introduce themselves.
  
2. The LPN/LVN is having a long discussion with a client diagnosed with diabetes who requires an amputation. At times during the conversation, the LPN/LVN continues looking at the client but becomes silent. Which of the following is the best advantage of this approach?

- (A) It gives the client time to think and reflect on what was said.
- (B) It gives the client the opportunity to end the conversation.
- (C) It allows the client to recall other tasks needing attention.
- (D) It prompts the client to fill in the silence with information.

3. The client says to the LPN/LVN, "I really like you and I think you really like me. Would you like to go on a date with me after I am discharged?" What is the most appropriate response by the LPN/LVN?

- (A) "This is a hospital, and I am here to take care of you during your illness."
- (B) "Why do you think I am available? I have been married for 10 years."
- (C) "Our policy requires that I report this comment to the hospital administrator."
- (D) "I have been asked out by clients before. I am not sure what I do to cause it."

4. The LPN/LVN is caring for a client recently diagnosed with type 1 diabetes mellitus. The client says, "I just can't believe that I am going to have to give myself shots every day." What is the priority statement for the LPN/LVN to make?

- (A) "I have cared for people who had to learn how to inject insulin. They adapted well after time."
- (B) "Do you have any family members who can help you with the daily insulin injections?"
- (C) "I have to go see another client, but I want to talk with you about this. I will be right back."
- (D) "Tell me more about how you plan to take care of yourself when you return home."

5. The LPN/LVN is working in the hospice unit. The client's partner approaches the nurse and says, "I won't be able to face life without my partner of over 50 years." Which of the following would be an appropriate response by the LPN/LVN? Select all that apply.

- (A) "Fifty years! That's a wonderful accomplishment!"
- (B) "Make every moment you have together really count."
- (C) "You seem to be upset, anticipating your partner's death."
- (D) "We'll make sure quality time is allotted for your goodbyes."
- (E) "You should focus on the good years you have had."
- (F) "I sense that you are looking ahead, to being alone."

6. The LPN/LVN is obtaining a medical history from the client with several chronic gastrointestinal conditions. Which of the following questions would best elicit the client's current emotional state?

- (A) "How many surgeries have you had in the past 5 years?"
- (B) "What are the pain medications you have been prescribed?"
- (C) "How do you handle your frequent insomnia?"
- (D) "Why haven't you consulted with a nutritionist?"

7. The unlicensed assistive personnel (UAP) tells the LPN/LVN, "I want to change my assignment for today. I will not take care of a client diagnosed with AIDS." What is the most appropriate statement for the LPN/LVN to make?

- (A) "Haven't you taken care of clients diagnosed with AIDS before?"
- (B) "Don't worry. I have taken care of clients diagnosed with AIDS with no problem."
- (C) "This is your assignment for today and you have to go through with it."
- (D) "What is your understanding about care of clients diagnosed with AIDS?"

8. The client in the adolescent psychiatric unit asks the LPN/LVN, "Do you hear those voices? They sound so frightening." Which of the following responses by the LNP/LVN would be the most appropriate?

- (A) "The voices around here sound friendly to me."
- (B) "Are they men's voices or women's voices?"
- (C) "I don't hear voices, but I can understand why that would scare you."
- (D) "Let's turn up the volume of the music, and that will distract you."

9. Family members of the client with dementia are visiting the memory care unit for the first time. They express concern to the LPN/LVN caring for their relative about the client's unobserved wandering. Which of the following responses by the LPN/LVN would be most appropriate?

- (A) "It's all right. We will take care of your relative's safety."
- (B) "We use wrist bands that signal if clients exit our doors."
- (C) "I worried about the same thing with my parent for years."
- (D) "We have a superb staff-to-client ratio, so that can't happen."

10. The LPN/LVN is caring for a client 5 days after a colostomy procedure. During colostomy care, the LPN/LVN observes the client vigorously rubbing the skin around the stoma before applying the colostomy pouch. What is the most appropriate statement for the LPN/LVN to make?



- (A) “Do you think you are ready to care for the colostomy after you go home?”
- (B) “Is there a family member who can help you care for the colostomy at home?”
- (C) “There is a step of colostomy care we need to review. Start at the beginning and show me how you do the care.”
- (D) “Do you think that you should read the written instructions about colostomy care before you try again?”



## Answers and Explanations

## CHAPTER QUIZ

1. The Answer is 6, 2, 4, 3, 5, 1

The LPN/LVN is caring for the client in the pediatric unit. The client's parents, whom the nurse has not met, approach the nurse at the nursing station. Arrange the following steps in the order that the LPN/LVN should perform them. All options must be used.

Strategy: Picture yourself and the parents at the moment of first contact. Think about what action comes next.

Category: Implementation/Health Promotion and Maintenance

The nurse and the parents introduce themselves.

The nurse brings the parents to a private area to talk.

The nurse invites the parents to talk about their questions on home care.

The nurse affirms the parents' ability to take care of their child at home.

The nurse follows up with literature about home care instructions.

The nurse documents the significant parts of the conversation.

2. The Answer is 1

The LPN/LVN is having a long discussion with a client diagnosed with diabetes who requires an amputation. At times during the conversation, the LPN/LVN continues looking at the client but becomes silent. Which of the following is the best advantage of this approach?

Strategy: “Best” indicates that there may be more than one response that appears correct.

Category: Implementation/Psychosocial Integrity

CORRECT: Rather than feel pressured to respond, the client can relax for a moment and reflect on the conversation.

The reason for using silence is to make the conversation more productive, not to end the dialogue.

The reason for using silence is to allow quiet focus, not to provide distraction.

Silence should not be used to make the client feel pressured to respond.

### 3. The Answer is 1

The client says to the LPN/LVN, “I really like you and I think you really like me. Would you like to go on a date with me after I am discharged?” What is the most appropriate response by the LPN/LVN?

Strategy: Eliminate incorrect answer choices.

Category: Implementation/Psychosocial Integrity

CORRECT: This response provides realistic information and is not confrontational.

“Why” questions can be confrontational. Even though realistic information is offered in this response, the opening statement implies disapproval and might put the client on the defensive.

This response is confrontational. The LPN/LVN should be able to take care of the situation right now. If the comment needs to be reported, the LPN/LVN should report it to the direct supervisor and follow the chain of command.

This response puts the focus on the nurse and is not therapeutic communication. Focus should remain on the client.

#### 4. The Answer is 4

The LPN/LVN is caring for a client recently diagnosed with type 1 diabetes mellitus. The client says, “I just can’t believe that I am going to have to give myself shots every day.” What is the priority statement for the LPN/LVN to make?

Strategy: Eliminate incorrect answer choices.

Category: Implementation/Psychosocial Integrity

This statement takes the focus away from the client and dismisses the client’s feelings.

This is a “yes/no” question, which does not allow the client to give information or express feelings. It also assumes that the client cannot care for self.

In this response, the focus is on the nurse. Remember that on the NCLEX, you have the time to provide emotional support right now.

**CORRECT:** Even though it is a statement, this response is open-ended and encourages the client to discuss feelings. The client has expressed concern about the insulin injection but may need to discuss feelings about the diagnosis of diabetes.

5. The Answer is 3 and 6

The LPN/LVN is working in the hospice unit. The client's partner approaches the nurse and says, "I won't be able to face life without my partner of over 50 years." Which of the following would be an appropriate response by the LPN/LVN? Select all that apply.

Strategy: For each response, remember the principles of therapeutic communication. Eliminate nontherapeutic responses to identify the best answer. You may need to "translate" responses to identify errors in therapeutic communication.

Category: Implementation/Psychosocial Integrity

The client's partner is not in the mood to celebrate; this response ignores the partner's grief.

This is an authoritarian response that instructs the client's partner to behave in a certain way, your way.

CORRECT: This response is empathetic and reflects the partner's feelings.

This response is a version of "Don't worry."

This is an authoritarian response that instructs the partner to think in a certain way, your way.

CORRECT: This response is empathetic and reflects the partner's feelings.

6. The Answer is 3

The LPN/LVN is obtaining a medical history from the client with several chronic gastrointestinal conditions. Which of the following questions would best elicit the client's current emotional state?

Strategy: Remember therapeutic communication. You want to hear feelings, not facts.

Category: Data Collection/Psychosocial Integrity

This is a closed-ended question that can be answered with a number or with “I don’t know.” It encourage a response that gives no insight into the client's emotional state.

This is a closed-ended question that can be answered with a list. It seeks facts and doesn't encourage a response that gives no insight into the client's emotional state.

CORRECT: This is an open-ended question that encourages the client to express feelings about the current health status and measures needed to improve it.

“Why” questions imply disapproval. This question could put the client on the defensive, discouraging any expression of feelings about dietary intake.

#### 7. The Answer is 4

The unlicensed assistive personnel (UAP) tells the LPN/LVN, “I want to change my assignment for today. I will not take care of a client diagnosed with AIDS.” What is the most appropriate statement for the LPN/LVN to make?

Strategy: Eliminate incorrect answer choices.

Category: Implementation/Psychosocial Integrity

This is a “yes/no” question and can be interpreted as confrontational.

This response gives false reassurance and does not address the concerns of the UAP.

This response is authoritarian and argumentative, and it does not address the concerns of the UAP.

CORRECT: This response is open-ended and allows the UAP to express feelings about care of a client diagnosed with AIDS. It seeks more information about the UAP’s knowledge of the care needed.

#### 8. The Answer is 3

The teenage client in the adolescent psychiatric unit asks the LPN/LVN, “Do you hear those voices? They sound so frightening.” Which of the following responses by the nurse would be the most appropriate?

Strategy: “Most appropriate” indicates that discrimination is required to answer the question. Remember therapeutic communication as well as scope of practice.

Category: Implementation/Psychosocial Integrity

This response contradicts the client’s experience and also moves the focus from the client to the nurse.

This response affirms the client’s delusions and is exploratory; outside the scope of LPN/LVN practice.

CORRECT: This response gives correct information and is empathetic, reflecting the client’s feelings.

This response is unnecessarily authoritative and removes focus from the client’s needs.



9. The Answer is 2

Family members of the client with dementia are visiting the memory care unit for the first time. They express concern to the LPN/LVN caring for their relative about the client's unobserved wandering. Which of the following responses by the LPN/LVN would be most appropriate?

Strategy: Remember therapeutic communication: Focus on assuring good client care.

Category: Implementation/Psychosocial Integrity

This "Don't worry" response discounts what the family members feel.

CORRECT: This response provides factual information and encourages further communication.

This response moves the focus from the client to the LPN/LVN.

The response negates the family members' concern and discourages further communication.

10. The Answer is 3

The LPN/LVN is caring for a client 5 days after a colostomy procedure. During colostomy care, the LPN/LVN observes the client vigorously rubbing the skin around the stoma before applying the colostomy pouch. What is the most appropriate statement for the LPN/LVN to make?

Strategy: Eliminate incorrect answer choices.

Category: Data Collection/Psychosocial Integrity

Asking the client for an explanation may be deemed confrontational. Also, this is a “yes/no” question, which does not encourage the client to give information or express feelings.

This question is closed-ended and judgmental. It assumes that the client does not have the ability to care for the colostomy.

**CORRECT:** This statement gives factual information. There is an increased risk of damage to the skin if the area around the stoma is rubbed vigorously. With this approach, the LPN/LVN can provide positive reinforcement for the steps of the procedure done correctly and give suggestions for improvement.

This question assumes that the client has not read the written instructions. The priority is to have the client demonstrate all steps of colostomy care.

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PART 3

PREPARING FOR THE NCLEX-PN<sup>®</sup>  
EXAM

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## CHAPTER 9

# HOW TO STUDY FOR THE NCLEX-PN<sup>®</sup> EXAM

Now that you've read about the various Kaplan test taking strategies, you are probably thinking, "Wow! This is great!" Most of you have started identifying why you are having difficulty answering application/analysis-level test questions. Some of you have already formulated a plan to master your NCLEX-PN<sup>®</sup> exam questions using the strategies outlined in this book, and are confident that you will pass the exam. Others are thinking, "This sounds great, but can I really answer questions using these strategies?"

The authors of this book work for Kaplan, the oldest test prep company in the nation. We have been preparing graduate nurses and international nurses for licensure exams for more than 35 years. We know what works to prepare for the exam and what doesn't work.



# Ineffective Ways to Prepare

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Here are a few of the biggest mistakes some NCLEX-PN<sup>®</sup> exam test takers make before test day.

## Relying on False Hopes

Some students use what is known as the “hope” method of study. “I hope that I don’t have questions about chest tubes on the test.” “I hope that I don’t have questions about medication on my test.” “I hope that I have questions about electrolytes because I did great on that test in school.” The “hope” method usually doesn’t work very well. The test pool contains thousands of questions. How many topics do you “hope” won’t be on your test?

## Lacking Respect for the Exam

Many candidates for the NCLEX-PN<sup>®</sup> exam are good students in school. Because of their school success, they expect to pass the exam with minimal preparation. After all, it’s just a test of minimum competency. These students do some studying, but they really believe there is no chance they might fail this exam. You might think that you can’t possibly fail, but if you

do not respect this exam and prepare for it correctly, you run the risk of failure!

All students know why they take the NCLEX-PN<sup>®</sup> exam. However, after interviewing hundreds of students, we have discovered that many have no idea what the exam content is. How can you effectively study for a test if you don't know what content the exam tests? Learn what is on the NCLEX-PN<sup>®</sup> exam and then you will realize that preparation with a planned method of study is essential.

## Cramming

Some students completed nursing school with a minimal understanding of nursing content. These students studied long and hard on the night before a nursing school test, cramming as many facts into their heads as they could remember. Because the test questions primarily involved recognition and recall, cramming worked for tests in nursing school. But as we said earlier, the NCLEX-PN<sup>®</sup> exam is not an exam about facts. It tests your ability to apply the knowledge that you have learned and to think critically. Recognition and recall will not work!

## Planning Poorly

As with all standardized exams, you must work on your areas of weakness. This is hard to do because there's usually a reason you're weak in an area. Some graduate practical/vocational nurses, for example, profess a weakness in or dislike for obstetrical nursing. Some students didn't understand the theory, while other students had a poor clinical experience

or didn't get to see many deliveries; still other students simply didn't like this rotation. Whatever the reason, it causes you to have a weakness in a particular area. In order to pass a standardized test, you must work on your areas of weakness.

Some students don't establish a plan of study. Other students establish a plan of study but don't follow it. You can buy review books, but if you don't apply yourself, they will do you no good.

# Effective Methods of Preparation

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To pass the NCLEX-PN<sup>®</sup> exam, you not only need to know nursing content, you also need to be able to apply the critical thinking skills we've just reviewed. Next, you need to be an expert on the content of the exam. What topics are usually included on the NCLEX-PN<sup>®</sup> exam? How is the content organized? And finally, you need to create a study plan, and make sure that you are able to cope with the testing experience.

So let's start by talking about some of the issues that you may be asking yourself.

Question: "I'm terrible at standardized tests. Is this really going to help me?"

Answer: Yes, these strategies will help you choose more correct responses when you take the NCLEX-PN<sup>®</sup> exam. Read this book—more than once if necessary—to learn the strategies. Then practice, practice, practice. Use the strategies to answer many, many test questions, and you will find yourself answering more and more questions correctly. Tear out the Chart of Critical Thinking Paths in Appendix A and consult it while you are answering practice test questions. This will help you become more comfortable with putting the strategies into practice. As you answer more and more questions, put the diagram aside and rely on your memory to identify and implement a critical thinking strategy.

Question: "Am I going to have enough time when I take the NCLEX-PN<sup>®</sup> exam to figure out which strategy to use?"

Answer: Timing is a concern on the NCLEX-PN<sup>®</sup> exam. You need to maximize your efforts on



each test question. Practice answering test questions using the various strategies we've outlined. As you get more proficient, you will discover that it takes you less time to identify the strategy or path that will lead you to the correct answer.

Question: "I don't have to use these strategies on every question, do I? I think I'll use them only when I can't figure out the correct answer on my own."

Answer: Wrong! You should use critical thinking to answer every question on the NCLEX-PN® exam to make sure that you pass. Follow the steps that we have outlined for every practice question that you answer as you prepare for the exam. If you practice these steps, you will not need to randomly guess the correct answer on the NCLEX-PN® exam.

Question: "So all I have to do is memorize the strategies, right?"

Answer: Just memorizing the various strategies will not ensure your success on the NCLEX-PN® exam. Remember, the exam does not test your ability to memorize either critical thinking strategies or the nursing content. The NCLEX-PN® exam tests your ability to think critically and use the nursing knowledge that you have. It's relatively easy to just memorize nursing content. The hard part is figuring out how to use this knowledge to make nursing decisions. It's relatively easy to memorize the critical thinking strategies. The hard part is to figure out which strategy to use on each and every question. That takes practice.

Question: "What if I use the strategies but still can't figure out the correct answer?"

Answer: It's not unusual that students will read a question, read the answers, and think "Huh? Something is missing." If you feel like something is missing, reread the question to determine if you have correctly identified what the question is asking. If you have identified the question correctly, then read the answer choices to make sure that you haven't missed the nursing concept contained in the answer choices.

Question: "Will these strategies work on every practice question that I answer?"

Answer: The critical thinking strategies discussed in this book will enable you to answer all kinds of multiple-choice test questions. The critical thinking strategies apply to test questions written at the application/analysis level and do not work with knowledge-based test questions. If you feel that the strategies don't work with the

practice questions you are answering, determine the level of difficulty of the questions you are working with. Are the practice questions knowledge-based, or are they at the application/analysis level of difficulty? Remember, the majority of questions that are of a passing level of difficulty on the NCLEX-PN® exam are at the application/analysis level of difficulty.

It's time for you to start your successful preparation for the NCLEX-PN® exam. Begin by identifying your strengths and weaknesses, as follows:

- Take as many diagnostic exams as you can.
- Identify your weaknesses in nursing content.
- Identify your weaknesses in test taking skills.

Next, decide if you need to take a review course. If you decide that this is the best way for you to prepare, ask yourself these questions:

- Is the course mainly a review of nursing content or memory techniques? This type of review won't help you put it all together on test day. You can know everything about heart failure, but if you don't know how to use this information to answer a question about heart failure correctly on the NCLEX-PN® exam, you will have difficulty on the exam. Are the strategies specific for the NCLEX-PN® exam?
- Are there plenty of opportunities for practice testing? You need to prove your competence by answering NCLEX-PN® exam-style test questions, so you should practice answering these questions. If the exam were about opening a sterile pack, what would you spend your time doing to prepare for the exam? Reading about opening a sterile pack or practicing opening a sterile pack? Are there exam-style questions included in the course? Do the questions require recall and recognition

of facts or application of nursing care principles? Remember, your NCLEX-PN® exam will consist mainly of analysis/application-level questions.

- What do students who have taken the course have to say about how it helped them prepare for the exam? If a review course boasts of a particularly high pass rate, ask to see their statistics. Be an informed consumer.
- Is there a guarantee? There are guarantees and there are empty promises. Make sure the course you are considering puts the guarantee in writing. Study the small print. Is your total tuition refunded? Do you have to fail the exam more than once?
- How much does it cost? This sounds easy, but “extras” can add up. Are there additional charges for books? Software? Registration fees?
- Is this course right for me?

And finally, create a realistic study schedule that works for you. Then make a vow to stick to that plan and reward yourself when you do. Spend at least 3 weeks before your exam date preparing. Don’t cram! Your content focus should be in understanding the principles of nursing care, not memorizing facts.

Stay away from people who are “prophets of doom.” You know the type. With the proper preparation you can and will pass the NCLEX-PN® exam. Keep a positive attitude.

You may need to consider some techniques for battling stress and managing the test day experience. Do any of these statements apply to you?

“I always freeze up on tests.”

“I need to pass to get my new job/promotion/commission.”

“My best friend/girlfriend/sister/brother did really well, but I won’t.”

“My hospital/family/parents won’t like it if I fail.”

“I’m afraid of losing concentration.”

“I’m afraid I’m not spending enough time preparing.”

If these sound familiar, you may want to mentally prepare yourself by understanding ways to manage test stress. Forcing yourself to identify and face fears may make you edgy at first but will significantly alleviate test stress in the long run by adding another dimension to your preparation.

# Mental Preparation<sup>\*</sup>

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## 1. Visualize

You have probably learned how to do this with clients; now it's your turn. Sit back and let your shoulders and arms relax. Close your eyes and imagine yourself in a relaxing situation—it can be fictional, but a real-life memory is best. Make it as detailed as possible. Think about the sights, the sounds, the smells, even the tastes that you associate with the relaxing situation. Keep your eyes shut; keep sinking back into your chair. Now that you're in that situation, start bringing your test in—think about the experience of taking the test while in that relaxing situation. Imagine how much easier it would be if you could take your test in that situation. Notice how much easier your test seems in that situation.

Here's another variation. Close your eyes and think about a situation in which you did well on a test. If you can't come up with one, pick a situation in which you did some good academic work that you were really proud of, or some other kind of genuine accomplishment. Not a fiction, mind you: it has to be from real life. Make it as detailed as possible. Think about the sights, the sounds, the smells, even the tastes that you associate with this experience of academic success. Now think about your test in line with that experience. Don't make comparisons between them. Just imagine taking your test with that same feeling of relaxed control.

## 2. Exercise

Whether it be jogging, walking, yoga, push-ups, or a pickup basketball game, physical exercise is a great way to stimulate the mind and body and improve one's ability to think and concentrate. A surprising number of those who prepare for standardized tests don't exercise regularly because they spend so much time preparing. Sedentary people—this is a medical fact—get less oxygen in the blood, and therefore to the brain, than active people.

## 3. Do the Following on Exam Day:

- Keep moving forward. By test day, do enough preparation with practice questions that it becomes an instinct to keep moving forward instead of getting bogged down in a difficult question. You don't need to get everything right to pass, so don't linger on a question that is going nowhere. The best test takers don't get bothered by difficult questions because they accept that everyone encounters them on the NCLEX-PN® exam.
- Don't listen to negative words or behavior. Don't be distracted by the ignorant babble or the behavior of other, less-prepared, less-skilled candidates around you. Negative thoughts lead to negative feelings and may interfere with performing your best on test day.
- Don't be anxious if other test takers seem to be working harder or answering questions more quickly. Continue to spend your time patiently but persistently thinking through your answers; it's going to lead to higher-quality test taking and better results. Set your own pace and stick to it.

- Keep breathing! Weak standardized test takers tend to share one major trait: forgetting to breathe steadily as the test proceeds. They do not know the value of proper breathing. They start holding their breath without realizing it, or begin breathing erratically or arrhythmically. This can hurt confidence and accuracy. Do what you can to instill an awareness of proper breathing before and during each study or testing section.
- Do some quick isometrics during the test. This is helpful especially if your concentration is wandering or energy is waning. For example, put your palms together and press intensely for a few seconds.

To effectively prepare for the NCLEX-PN<sup>®</sup> exam, first identify your strengths and weaknesses, and then choose an effective method of study that works for you. Then use mental preparation techniques to alleviate stress and manage your test day experience.

\* Some of these methods were originally conceptualized by Dr. Emile Coué, who in the 1920s told everyone that the key to a happy life was to constantly repeat the phrase, “Every day in every way I am getting better and better.” As advice to test takers, that isn’t bad at all!



## CHAPTER 10

# THE LICENSURE PROCESS

The process of obtaining an American nursing license requires a definite sequence of actions by the candidate. Because this may be your first experience with the LPN/LVN licensure process, and because there are no established test dates, you may have difficulty knowing exactly how to complete the paperwork and go through the process. This chapter will give you a checklist to follow when planning to take the NCLEX-PN<sup>®</sup> exam. This is a general list, so you must individualize it according to the requirements for the state or province in which you wish to become licensed. (For a listing of the website of each U.S. state board of nursing, see Appendix D, State Boards of Nursing.) We will outline the questions that you need to ask, and the steps you need to take to complete the licensure process.





# How to Apply for the NCLEX-PN<sup>®</sup> Exam

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During your last semester of nursing school, you will be given the following applications:

Application for licensure that goes to your state board of nursing/regulatory body.

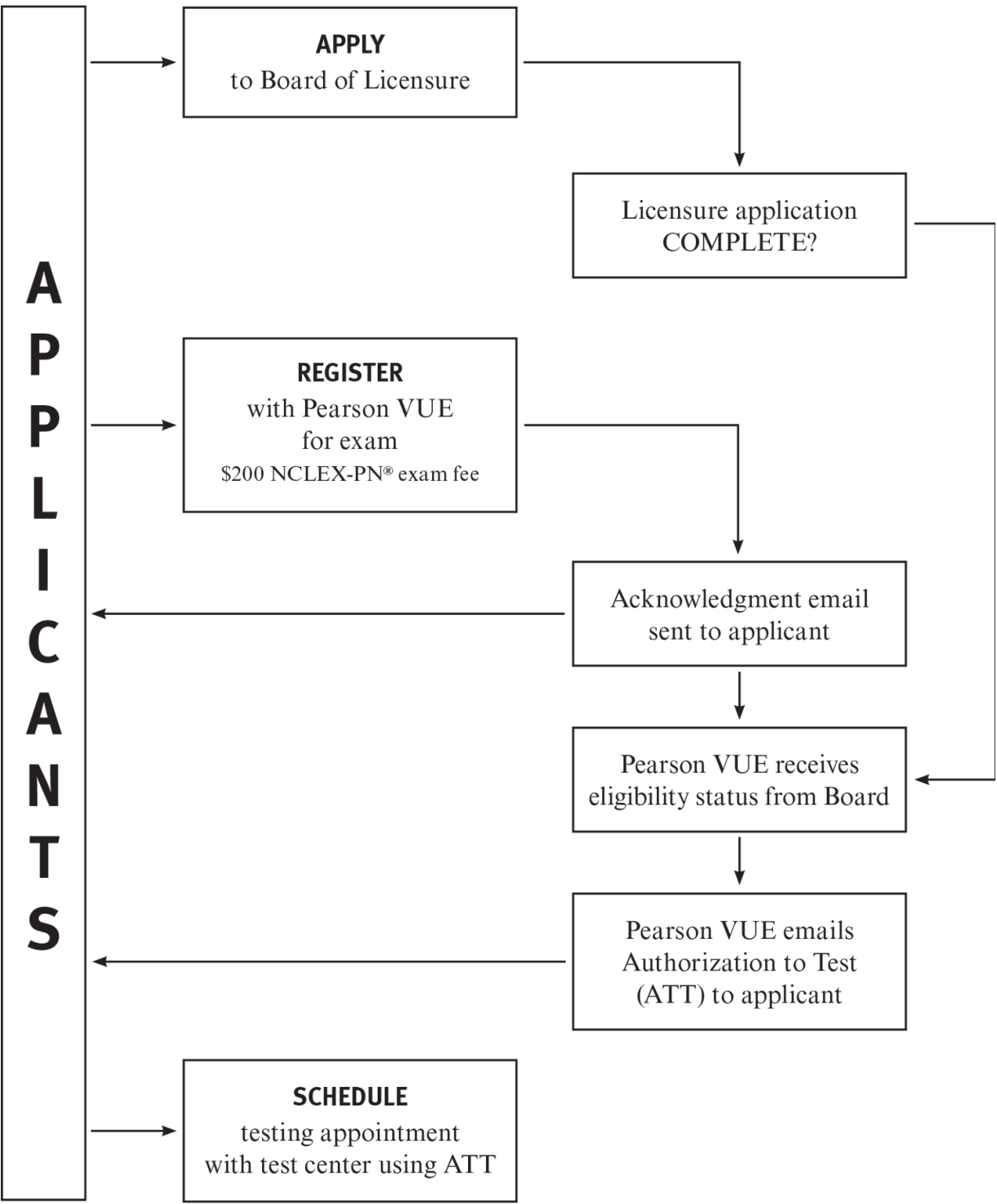
Application for the NCLEX-PN<sup>®</sup> exam that goes to Pearson VUE.

On a predetermined date, you will submit the completed forms and the required licensure fees to your nursing school.

## Application Fees

- The NCLEX-PN<sup>®</sup> examination fee is \$200 (\$360 CAD). Additional licensure fees are determined by each state nursing board. Refer to your state board of nursing's website to determine your state's fee.
- You are responsible for submitting the completed test application and the \$200 fee to Pearson VUE. All applications will be processed by phone or online.

The Registration Process



Applicant must APPLY, REGISTER, and SCHEDULE

## Registration

You can register for the NCLEX-PN<sup>®</sup> with Pearson VUE using either of the following two methods:

Internet registration: To register online, go to [pearsonvue.com/nclex](https://pearsonvue.com/nclex) (the NCLEX candidate website). Payment is by credit, debit, or prepaid card (using Visa, MasterCard, or American Express only).

Telephone registration: Call VUE NCLEX Candidate Services at 1-866-496-2539 (1-866-49-NCLEX). To register by phone, you must pay using a Visa, MasterCard, or American Express credit or debit card. Even if you register by phone, you must provide an email address to receive communications from Pearson VUE about your registration.

Pearson VUE does not accept exam registrations submitted by mail.

Some states require that the testing application form and fee be sent along with the licensure application and fee.

For more information, visit [ncsbn.org](https://ncsbn.org) and download the 2019 NCLEX Candidate Bulletin. For questions regarding registering to take the NCLEX-PN<sup>®</sup> exam, your Authorization to Test (ATT), acceptable forms of identification, or comments about the test center, visit the NCLEX candidate website ([pearsonvue.com/nclex](https://pearsonvue.com/nclex)) or contact:

NCLEX Candidate Services

1-866-49-NCLEX

<https://www.ncsbn.org/exam-contacts.htm>

NCLEX-PN® Examination Program  
Pearson Professional Testing  
5601 Green Valley Drive  
Bloomington, MN 55437-1099  
pvamericascustomerservice@pearson.com

## How Do You Know Your Application Has Been Received?

You will receive a card from your state board confirming that all of your information has been received.

## Potential Problems with Licensure Application

Some states require that your permanent transcript be mailed with your application.

Here is a checklist to follow to avoid problems with your application:

- Have you met all requirements for graduation? Do you have any electives still outstanding?
- Has your nursing school received a permanent transcript for any credits that you transferred from another institution?
- Do you owe any fines or have any unpaid parking tickets? (This can delay the release of your permanent transcript. Check at your nursing school office, just to be sure.)
- Some states require that a statement be sent from your nursing school stating that you have met all requirements for graduation.

- Did you change your mind about the state to which you want to apply for licensure? If so, you must apply to the new state—and forfeit the original application fee.

## What If You Want to Apply for Licensure in a Different State?

If you plan to apply for licensure in a different state from the one in which you are attending practical/vocational nursing school, contact the state board of nursing in the state in which you wish to become licensed (refer to Appendix D, State Boards of Nursing).

Here's a checklist for obtaining a license in another state:

- Contact the state board of nursing of that state and find out what their requirements are for licensure.
- Find out what their fees are.
- Request a new candidate application for licensure.

After you pass the NCLEX-PN<sup>®</sup> exam, you will receive your nursing license from the state in which you applied for licensure regardless of where you took your exam. For example, if you applied for licensure in Michigan, you can take the test in Florida if you wish. You would then receive a license to practice as an LPN in Michigan because that is where you applied for licensure.

## When Can You Schedule Your NCLEX-PN<sup>®</sup> Exam?

Pearson VUE will send you a document entitled “Authorization to Test” (ATT). The ATT will be sent to you via email at the email address you provided when you registered. You will be unable to schedule your test date until you receive this form.

On the ATT is your assigned candidate number; you will need to refer to this when scheduling your exam. Your ATT is valid for a time determined by the individual state board of nursing/regulatory body, and you must test before your ATT expires. If you don’t, you will need to reapply to take the exam and pay the testing fees again. With your ATT, you will receive a list of test centers. You can schedule your NCLEX-PN<sup>®</sup> exam using the following procedures:

- Log on to the NCLEX Candidate Website at [pearsonvue.com/nclex](https://pearsonvue.com/nclex)
- Call NCLEX Candidate Services
  - United States and Canada: 1-866-496-2539 (1-866-49-NCLEX) (toll-free)
  - Asia Pacific Region: +852-3077-4923 (pay number)
  - Europe, Middle East, Africa: +44-161-855-7445 (pay number)
  - India: 91-120-439-7837 (pay number)
  - All other countries not listed above: 1-952-905-7403 (pay number)

Candidates with hearing impairments who use a Telecommunications Device for the Deaf (TDD) can call the U.S.A. Relay Service at 1-800-627-3529 (toll-free) or the Canada & International Inbound relay service at 1-605-224-1837 (pay number).

Those with special testing requests, such as persons with disabilities, must call the NCLEX-PN<sup>®</sup> Program Coordinator at NCLEX Candidate Services at

one of the numbers listed above. If you require special accommodations, you cannot schedule your exam through the NCLEX Candidate Website.

There is a space on the ATT for you to record the date and time of your scheduled exam. You will also receive confirmation of your scheduled date and time.

## Potential Rescheduling Problems

- You must test prior to the expiration date of your ATT. If you miss your appointment, you forfeit your testing fees and must reapply to both the state board of nursing/regulatory body and Pearson VUE.
- If you wish to change your appointment, you must notify Pearson VUE during business hours, at least 24 hours prior to your scheduled appointment. Call one of the numbers listed above or go the NCLEX candidate website ([pearsonvue.com/nclex](https://pearsonvue.com/nclex)). If your test date is on a Saturday, Sunday, or Monday, make sure to call on or before Friday.

Do not call the test site directly or leave a message if you are unable to take your test on the scheduled date. You must follow the procedure outlined here.

## When Will You Take the Exam?

The earliest date on which you can take the NCLEX-PN<sup>®</sup> exam varies depending on your state, but the majority of students test approximately 45 days after the date of their graduation. Variables include when you submit the applications and fees, the length of time the ATT is valid,

personal factors (weddings, births, vacations), and job requirements. Each state determines the requirements for graduate practical/vocational nurses, licensure pending. If you are working as a graduate practical/vocational nurse, you must be knowledgeable about the rules in your state.



# Taking the Exam

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## What Happens on the Day of My NCLEX-PN® Exam?

Arrive at the test center at least 30 minutes before your scheduled test time. Wear layered clothing—the rooms may be cool in the morning but can warm up as the day progresses.

Here's a checklist of things to bring on the day of the exam:

- Your Authorization to Test (ATT). (Although your ATT is no longer required for admission to your exam, you may wish to refer to it.)
- One form of unexpired, government-issued, signed identification (ID) that includes a picture. It must exactly match the first and last names you provided when registering. If you have changed your hair color, lost weight, or grown a beard, have a new picture ID made before test day. Acceptable forms of ID include driver's license, state/territorial/provincial identity card, passport, and U.S. military ID.
- A snack and something to drink.
- Do not bring any study materials to the test center.

Check-in procedure:

- Present a valid, acceptable form of ID.

- Provide your digital signature, take a palm vein scan, and have your photograph taken.
- Agree to the Candidate Statement via digital signature.
- Seal all electronic devices in a plastic bag provided by the test center.
- Place all other personal belongings in secure storage outside the testing room. This includes watches, large jewelry, scarfs and hats, lip balm, food and drink, and medical devices.

Earplugs are available on request. Request them, in case you find yourself distracted by background noise.

You will be provided an erasable note board for scratch work.

## Where Will I Take My Test?

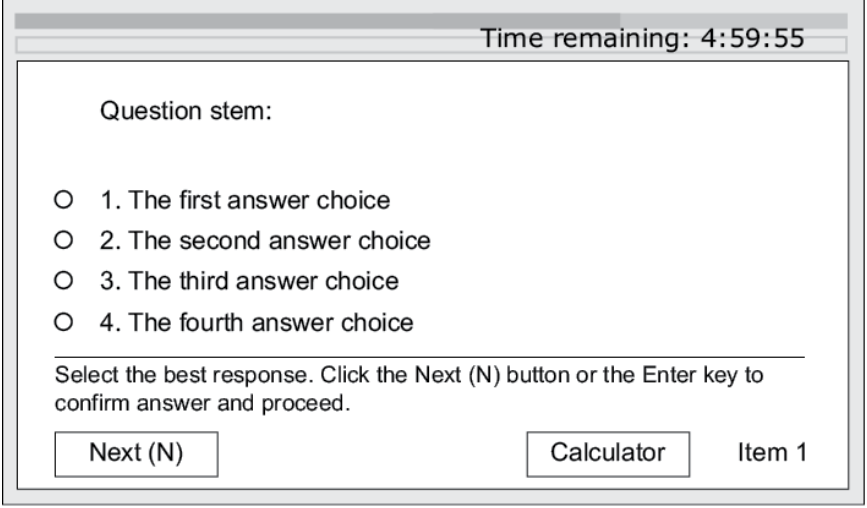
You will be in a room separate from the rest of the test center. Many testing sites consist of a room with 10 to 15 computers placed around the outside walls. Each computer sits on a full-size desk, with an adjustable chair for you to sit on. There are dividers between desks, but you will be able to see the person sitting next to you. There is a picture window from which the proctor will observe each person testing. There are also video cameras and sound sensors mounted on the walls to monitor each candidate.

## What Will the Computer Screen Look Like?

The number of the question you are answering is located in the lower-right side of your computer screen. In the upper-right corner is a digital clock that counts down from 5:00—representing the five hours you have to

complete the short tutorial that begins the exam, the exam itself, and all breaks.

If the question is a traditional four-option, text-based, multiple-choice question, the question stem is located in the top half of the screen and the four answer choices are located in the lower half of the screen (Figure 1). Radio buttons are in front of each answer choice.



Time remaining: 4:59:55

Question stem:

- ☐ 1. The first answer choice
- ☐ 2. The second answer choice
- ☐ 3. The third answer choice
- ☐ 4. The fourth answer choice

---

Select the best response. Click the Next (N) button or the Enter key to confirm answer and proceed.

Next (N) Calculator Item 1

Figure 1

You will notice that there are two buttons at the bottom of the computer screen. You use the Next (N) button to confirm your answer selection and move to the next question. Click the Calculator button to display a drop-down calculator that can be used to perform computations.

If the question is an alternate format question that may have more than one correct answer, you will see the phrase “Select all that apply” between the stem of the question and five or six answer choices. A small box is in front of each answer choice. The Next (N) button and Calculator button are at the bottom of the computer screen.

If the question is a hot spot alternate format question, the screen will contain a graphic or a picture. The Next (N) button and Calculator button are at the bottom of the computer screen.

If the question is a fill-in-the-blank alternate format question, a text box will be under the question. The Next (N) button and Calculator button are at the bottom of the computer screen.

If the question is a drag-and-drop/ordered response alternate format question, the unordered options will be under the question and to the left. The space for the ordered response will be to the right of the unordered options. The Next (N) button and Calculator button are at the bottom of the computer screen.

If the question is a chart/exhibit alternate format question, it will include the following prompt after the question stem: “Click on the exhibit button below for additional client information.” The Exhibit button is located at the bottom of the computer screen between the Next (N) button and the Calculator button. Click on the Exhibit button to display a pop-up box containing three tabs. Click on each of the tabs to display information needed to answer the question.

If the question is an audio alternate format question, the question will contain an audio clip that you must listen to in order to answer the question. Click on the Play button (a right-pointing arrow) to listen to the clip. A slider bar allows you to adjust the volume at which you hear the clip. If you want to listen to the audio clip more than once, you can click on the Play button again.

If the question is a graphics alternate format question, each of the four answer choices will be a graphic instead of text.

## How Do I Use the Calculator?

Using the mouse, click on the Calculator button, and a drop-down calculator will appear on the computer screen. Use the mouse to click on the calculator keys. Remember, the diagonal or slash (/) key is used for division. When you are through with your calculations, click on the Calculator button again, and the calculator will disappear.

## How Do I Select an Answer Choice for Traditional Four-Option, Multiple-Choice Questions?

You will use a two-step process to answer each question. Read the question and select an answer by using the mouse to click on the radio button preceding your answer choice. Your answer is now highlighted. When you are certain of your answer, click on the Next (N) button or press the Enter key to confirm your answer. Your answer is now locked in and a new question will appear on the screen. You are not able to change your answer after clicking on the Next (N) button or pressing the Enter key, so be certain of your answer before you do so.

After your answer is entered into the computer, the computer selects a new question for you based on the accuracy of your previous answer and the components of the NCLEX-PN® exam test plan. If you answer a question correctly, the next question selected by the computer is more difficult. If

you answer a question incorrectly, the next question selected by the computer is easier.

## What If I Want to Change the Answer That I Have Highlighted?

If you want to change the highlighted answer, click on a different answer choice. Your answer is not locked in until you click on the Next (N) button or press the Enter key.

Even if you've never used a computer before, don't panic. You will be given instructions at the beginning of the test, and you will have to answer three tutorial questions before your test begins. These questions allow you to practice using the mouse to select an answer.

## How Do I Select an Answer Choice for Select All That Apply Questions?

Read the question and click on the small box in front of the answer choice you want. A small check will appear in the box. Click on each answer choice that answers the question.

## What If I Want to Change an Answer That I Have Checked?

If you change your mind and don't want an answer choice that you have selected, just click again on the small box in front of that answer choice

and the check will disappear. When you are certain of your answer, click on the Next (N) button or press the Enter key to confirm your answer. Your answer is now locked in and a new question appears on the screen.

## How Do I Select an Answer Choice for Hot Spot Questions?

To answer a hot spot alternate format question, just click on the area of the graphic or picture that answers the question.

## What If I Want to Change the Area That I Have Selected?

If you change your mind and want to select another area of the graphic or picture, just use your mouse to click on the area that you want and the original selection disappears. When you are certain of your answer, click on the Next (N) button or press the Enter key to confirm your answer. Your answer is now locked in and a new question appears on the screen.

## How Do I Enter an Answer Choice for Fill-in-the-Blank Questions?

To enter an answer for a fill-in-the-blank question, just use the keyboard to select the numbers or letters you want. If a unit of measurement already appears next to the answer box on the screen, be sure you enter numbers only into the answer box; adding a unit of measurement may cause your answer to be wrong.

## What If I Want to Change What I Have Entered in the Text Box?

If you change your mind and want to enter another answer in the text box, just backspace over the answer you entered and then use the keyboard to enter another answer. When you are certain of your answer, click on the Next (N) button or press the Enter key to confirm your answer. Your answer is now locked in and a new question appears on the screen.

## How Do I Select Options for Drag-and-Drop/Ordered Response Questions

To put the responses in the correct order, click on the option you think should come first, hold down the button on the mouse, and drag the option over to the box on the right side of the screen. You may also highlight the option in the box on the left side and then click the arrow key that points to the box on the right side to move the option. Do the same with each response in the proper order.

## What If I Want to Change the Order of My Responses?

If you change your mind about the order of a response, click on it with the mouse and drag it back to the left side of the screen or use the arrow key as described above. To complete the question, you must move all options from the box on the left side of the screen to the box on the right side. When you are certain of your answer, click on the Next (N) button or press the Enter key to confirm your answer. Your answer is now locked in and a new question appears on the screen.



## How Do I Enter or Change an Answer Choice for Chart/Exhibit, Audio, and Graphics Alternate format Questions?

Chart/exhibit, audio, and graphics alternate questions all use a four-option, multiple-choice format, so you can enter or change your answer choices just as you would for a traditional text-based, four-option, multiple-choice question.

## Do I Get Any Breaks?

You will receive an optional break at the end of two hours of testing. There will be a pre-programmed prompt offering you a break. Leave the testing room, stretch your legs, and eat your snack. Take some deep, cleansing breaths and get yourself ready to go back into the testing room. The computer will offer you another optional break after 3½ hours of testing. We recommend that you take it unless you feel you're on a roll.

You may take a break at any time during your test, but the time that you spend away from your computer is counted as a part of your five hours of total testing time. Kaplan recommends that you take a short (2–5 minute) break if you are having trouble concentrating. Take time to go to the restroom, eat your snack, or get a drink. This will enable you to maintain or regain your concentration for the test. Remember, every question counts! If you need to take a break, raise your hand to notify the test administrator. You must leave the testing room, and you will be required to take a palm vein scan before you are allowed to resume your test.

## How Will I Know When My Test Ends?

A screen will appear on your computer that states, “Your test is concluded.” You will then be required to answer several exit questions. These are a few multiple-choice questions about your response to the examination experience. They do not count toward your results.

## How Long Will It Take to Receive My Results?

Your results are sent to you by your state board of nursing. Each state board determines when the NCLEX-PN® exam results are released. In the following jurisdictions, you may access your “unofficial” results two business days after taking your examination via the NCLEX® candidate website (for a \$7.95 fee):

Alaska, Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Northern Mariana Islands, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, U.S. Virgin Islands, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming

For most states, you will receive your official results approximately six weeks after your test date.



## CHAPTER 11

# TAKING THE TEST MORE THAN ONCE

Some people may never have to read this chapter, but it's a certainty that others will. The most important advice we can give to repeat test takers is: Don't despair. There is hope. We can get you through the NCLEX-PN® exam.



# You Are Not Alone

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Think about that awful day when the big brown envelope arrived. You just couldn't believe it. You had to tell family, friends, your supervisor, and coworkers that you didn't pass the NCLEX-PN<sup>®</sup> exam. When this happens, each unsuccessful candidate feels like he or she is the only person who has failed the exam.

# How to Interpret Unsuccessful Test Results

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Most unsuccessful candidates on the NCLEX-PN® exam will usually say, “I almost passed.” Some of you did almost pass, and some of you weren’t very close. If you fail the exam, you will receive a diagnostic profile from NCSBN. In this profile, you will be told how many questions you answered on the exam. The more questions you answered, the closer you came to passing. The only way you will continue to get questions after you answer the first 85 is if you are answering questions close to the level of difficulty needed to pass the exam. If you are answering questions far above the level needed to pass or far below the level needed to pass, your exam will end at 85 questions.

[Figure 1](#) on the next page shows a representation of what happens when a candidate fails in 85 questions. This student does not come close to passing. In 85 questions, this student demonstrates an inability to consistently answer questions correctly at or above the level of difficulty needed to pass the exam. This usually indicates a lack of nursing knowledge, considerable difficulties with taking a standardized test, or a deficiency in critical thinking skills.

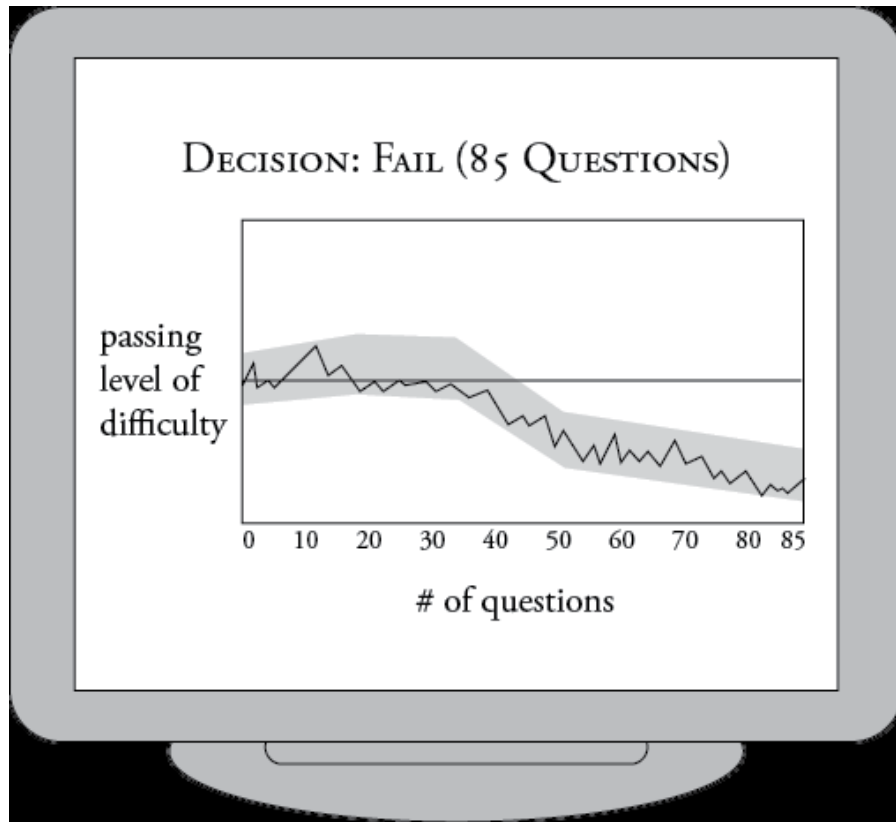


Figure 1

Figure 2 shows what happens when a candidate takes all 205 questions and fails. This candidate “almost passed.” The candidate answers question 204 and the computer does not make a determination when it selects the last question. If the last question is below the level of difficulty needed to pass, the candidate fails.

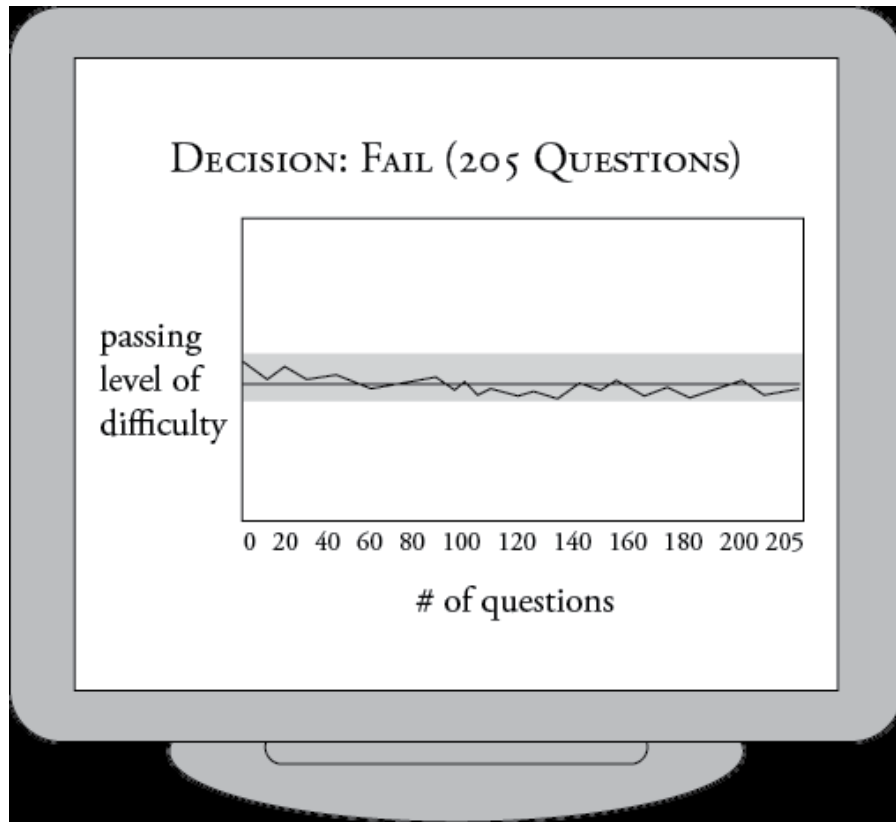


Figure 2

If the last question is above the level of difficulty needed to pass, the candidate passes. If you took a test longer than 85 questions and failed, you were probably familiar with most of the content you saw on the exam but you may have difficulty using critical thinking skills or taking standardized tests.

The information contained on the diagnostic profile helps you identify your strengths and weaknesses on this particular NCLEX-PN® exam. This knowledge will help you identify where to concentrate your study when you prepare to retake the NCLEX-PN® exam.



# Should You Test Again?

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Absolutely! You completed your nursing education to become an LPN/LVN. The initial response of many unsuccessful candidates is to declare, “I’m never going back! That was the worst experience of my life! What do I do now?”

When you first received your results, you went through a period of grieving—the same stages that you learned about in nursing school. Three to four weeks later, you find that you want to begin preparing to retake the NCLEX-PN® exam.



# How Should You Begin?

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You should prepare in a different way this time. Whatever you did to prepare last time didn't work well enough. The most common mistake made by candidates who failed is to assume that they did not study hard enough or learn enough content. For some of you, that's true. But for the majority of you, memorizing more content does not mean more right answers. It could simply mean more frustration for you.

The first step in preparing for your next exam is to make a commitment that you will test again. Decide when you want to schedule your test and allow yourself enough time to prepare. Mark this test date on your calendar. You can do all of this before you send in your fees and receive your authorization to test. Remember, you cannot retake the NCLEX-PN® exam for 45 to 90 days, depending on your state board of nursing/regulatory body, so you may as well use this time wisely.

The next step is to figure out why you failed the NCLEX-PN® exam. Check off any reasons that pertain to you:

☐

I didn't know the nursing content.

☐

I memorized facts without understanding the principles of client care.

☐

- ☐ I had unrealistic expectations about the NCLEX-PN® exam test questions.
- ☐ I had difficulty correctly identifying THE REWORDED QUESTION.
- ☐ I had difficulty staying focused on THE REWORDED QUESTION.
- ☐ I found myself predicting answer choices.
- ☐ I did not carefully consider each answer choice.
- ☐ I am not good at choosing answers that require me to establish priorities of care.
- ☐ I answered questions based on my real-world experiences.
- ☐ I did not cope well with the computer-adaptive experience.
- ☐ I thought I would complete the exam in 85 questions.
- ☐ When I got to question 180, I totally lost my concentration and just answered questions to get through the rest of the exam.

After determining why you failed, the next step is to establish a plan of action for your next test. Remember, you should prepare differently this time. Consider the following when setting up your new plan of study.

**You've seen the test.**

You may wish that you didn't have to walk back into the testing center again, but if you want to be a licensed practical/vocational nurse, you must go back. This time you will have an advantage over the first-time test taker: you've seen the test! You know exactly what you are preparing for, and there are no unknowns. The computer will remember what questions you took before, and you will not be given any of the same questions. However, the content of the questions, the style of the questions, and the kinds of answer choices will not change. You will not be surprised this time!

## Study both content and test questions.

By the time you retest, you will be out of nursing school for 6 months or longer. Remember that old saying, "What you are not learning, you are forgetting." Because this is a content-based test about safe and effective nursing care, you must remember all you can about nursing theory in order to select correct answers. You must study content that is integrated and organized like the NCLEX-PN® exam.

You must also master exam-style test questions. It is essential that you be able to correctly identify what each question is asking. You will not predict answers. You will think about each and every answer choice to decide if it answers the reworded question. In order to master test questions, you must practice answering them. We recommend that you answer hundreds of exam-style test questions, especially at the application level of difficulty.

## Know all of the words and their meanings.

Some students who have to learn a great deal of material in a short period of time have trouble learning the extensive vocabulary of the discipline. For example, difficulty with terminology is a problem for many good students who study history. They enjoy the concepts but find it hard to memorize all of the names and dates that allow them to do well on history tests. If you are one of those students who have trouble memorizing terms, you may find it useful to review a list of the terminology that you must know to pass the NCLEX-PN® exam. There is a list of those words at the end of this book.

## Practice test taking strategies.

There is no substitute for mastering the nursing content. This knowledge, combined with test taking strategies, will help you to select a greater number of correct answers. For many students, the strategies mean the difference between a passing test and a failing test. Using strategies effectively can also determine whether you take a short test (85 questions) or a longer test (up to 205 questions).

## Evaluate your testing experience.

Some students attribute their failure to the testing experience. Comments we have heard include:

“I didn’t like answering questions on the computer.”

“I found the background noise distracting. I should have taken the earplugs!”

“I looked up every time the door opened.”

“I should have taken a snack. I got so hungry!”

“After 2½ hours I didn’t care what I answered. I just wanted the computer to shut off!”

“I didn’t expect to be there for four hours!”

“I should have rescheduled my test, but I just wanted to get it over with!”

“I wish I had taken aspirin with me. I had such a headache before it was over!”

Do any of these comments sound familiar? It is important for you to take charge of your testing experience. Here’s how:

- Choose a familiar testing site.
- Select the time of day that you test your best. (Are you a morning person or an afternoon person?)
- Accept the earplugs when offered.
- Take a snack and a drink for your break.
- Take a break if you become distracted or fatigued during the test.
- Contact the proctors at the test site if something bothers you during the test.
- Plan on testing for five hours. Then, if you get out early, it’s a pleasant surprise.
- Say to yourself every day, “I will pass the NCLEX-PN® exam.”




## CHAPTER 12

# ESSENTIALS FOR INTERNATIONAL NURSES

Many of you have years of nursing experience in your home country. Now you are preparing for the NCLEX-PN<sup>®</sup> exam so you can be licensed to practice your profession in the United States. Because of Kaplan's extensive experience preparing nurses who were educated in other countries, we are very aware of the special issues that you face when trying to pass the NCLEX-PN<sup>®</sup> exam. Your special concerns will be discussed in this chapter.

Many nurses educated outside of the United States have not had the experience of taking a test that combines objective multiple-choice questions with alternate format questions. Your testing experience may have been limited to oral exams or writing answers to essay and short answer questions. Multiple-choice tests are used in the United States because they measure knowledge more objectively and are easier to administer to large groups of people. In order to pass the NCLEX-PN<sup>®</sup> exam, you must demonstrate that you are a safe and effective nurse by correctly answering predominantly multiple-choice questions along with alternate format question types, including those that require you to select more than one response, fill in the blank, or identify a "hot spot" (a specific area on a picture or graph).



# NCLEX-PN<sup>®</sup> Exam Administration Abroad

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NCSBN administers the NCLEX-PN<sup>®</sup> exam in selected international locations including Australia, Canada, England, Hong Kong, India, Japan, Mexico, the Philippines, and Taiwan. (Testing is temporarily unavailable in Germany.) Please see [ncsbn.org](https://ncsbn.org) for details and [pearsonvue.com/nclex](https://pearsonvue.com/nclex) to locate a test center near you.

International sites provide greater convenience for international nurses to take the NCLEX-PN<sup>®</sup> exam. The international administration does not circumvent any regulations posed by the state boards of nursing, and the test sites are subject to the same security and procedures followed in U.S. test sites. If you choose to take the test at one of these sites, you must pay an additional \$150 international scheduling fee plus a Value Added Tax (VAT) where applicable.

# The CGFNS<sup>®</sup> Certificate

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In order to apply for licensure as an LPN/LVN in the United States, many U.S. state boards of nursing require internationally educated LPN/LVNs to obtain a certificate from the Commission on Graduates of Foreign Nursing Schools (CGFNS<sup>®</sup>). Some states require that this process be completed prior to taking the NCLEX-PN<sup>®</sup> exam. The process of obtaining a CGFNS<sup>®</sup> certificate includes (1) a review of your secondary and nursing education credentials and original nursing program, (2) passing the CGFNS<sup>®</sup> exam that tests nursing knowledge, and (3) obtaining a minimum score on a designated English language proficiency exam.

The CGFNS<sup>®</sup> exam is a two-part test of nursing knowledge. Nurses who pass this exam have been shown to be more likely to pass the NCLEX-PN<sup>®</sup> exam on the first try than nurses who have not passed the CGFNS<sup>®</sup>. This exam can be taken overseas at a number of international testing sites run by CGFNS<sup>®</sup> or at selected sites in the United States.

Applications for the CGFNS<sup>®</sup> exam are free, and you may apply online at [cgfns.org](https://cgfns.org). Go to [cgfns.org](https://cgfns.org) for further information. Only online applications for the CGFNS<sup>®</sup> Certification Program are accepted. On the CGFNS<sup>®</sup> website, you will also find application deadlines and test dates. With an online application, you can submit your educational and professional documentation, choose a location and date for your exam, and pay fees by



credit card. The online CGFNS Qualifying Exam<sup>®</sup> is administered in March, July, September, and November during a five-day testing window in each of these months.

To find out about a particular state's requirements for international nurses, call that state's board of nursing and request an application packet for initial licensure as an internationally educated LPN/LVN. You can also visit your chosen state's website using the key words "Board of Nursing" and the state name. The website URL for each of the state boards of nursing in the United States is also listed in Appendix D.

Regarding the CGFNS<sup>®</sup> English proficiency requirements, the following information will help you register for the appropriate exams. Remember that these exam results are usually only valid for two years, so plan accordingly to avoid retakes. For more information about preparing for these exams, see the Kaplan English Programs section at the end of this chapter.

TOEFL<sup>®</sup>, TWE<sup>®</sup>, and TSE<sup>®</sup>

Educational Testing Service

P.O. Box 6151

Princeton, NJ 08541-6151

Phone: 1-800-468-6335 (United States, U.S. Territories, Canada)

Phone: 1-609-771-7100 (all other locations)

Fax: 1-610-290-8972

Website: [www.ets.org/toefl](http://www.ets.org/toefl)

TOEIC<sup>®</sup> Testing Program

Educational Testing Service

Rosedale Road  
Princeton, NJ 08541  
Phone: 1-609-771-7170  
Fax: 1-610-628-3722  
Email: [toeic@ets.org](mailto:toeic@ets.org)  
Website: [www.ets.org/toeic](http://www.ets.org/toeic)

IELTS® International  
Website: [www.ielts.org](http://www.ielts.org)



# Work Visas

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For the most current information on visa requirements, contact the nearest U.S. embassy or consulate in your home country or the nearest regional office of the Immigration and Naturalization Service if you already live in the United States. You can also contact CGFNS® by telephone at 1-215-222-8454 or through its website at [cgfns.org](https://www.cgfns.org).



# Nursing Practice in the United States

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Some international LPN/LVNs find nursing in the United States similar to nursing as they learned it in their country. For others, nursing in the United States is very different from what they learned or experienced in their home country. The NCLEX-PN® exam may ask you questions about procedures that are unfamiliar to you. You may be asked questions about diets and foods that are new to you. In order to be successful on the NCLEX-PN® exam, you must be able to correctly answer questions about nursing as it is practiced in the United States.

Here is an overview of services and skills that LPN/LVNs are expected to perform:

- LPN/LVNs are involved with prevention, early detection, and treatment of illness for people of all ages.
- LPN/LVNs care for the whole person, not just an illness. Their focus is on client needs; that is, how a client will respond to an illness.
- LPN/LVNs are professionals who are responsible for their actions.
- LPN/LVNs must communicate with clients and all the members of the health care team: RNs, unlicensed assistive personnel (UAPs), physicians, dietitians, pharmacists, therapists, technicians, and social workers.

- LPN/LVNs serve as clients' advocates; that is, they counsel clients and make sure their rights are protected.
- LPN/LVNs help clients understand the health care system and assist them to make decisions about their health care.
- LPN/LVNs are assertive and ask questions of other health care professionals when necessary, including physicians. Their style of communication is polite and professional but very direct.
- LPN/LVNs are responsible for meeting the needs of clients whose care involves high-tech equipment.
- LPN/LVNs are responsible for basing their actions on knowledge and acceptable nursing practice.
- LPN/LVNs, not families, are responsible for all the hands-on nursing care for clients in the hospital setting.
- LPN/LVNs are responsible for teaching clients and their families how to manage their health care needs.

# U.S.-Style Nursing Communication

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An issue of special concern for international nurses is therapeutic communication. Correctly answering the questions about communication can be difficult for some nurses educated in the United States. These questions become a special challenge to test takers for whom English is a second language, or for test takers who do not yet fully understand American-style communication.

## Key features of U.S.-style communication in nursing:

- Validate the client's experience and feelings by responding to the client verbally. Ask questions that relate directly to what the client says.
- Direct the client's behavior to promote comfort and well-being. Do not patronize or reject the client by imposing a value judgment.
- Maintain eye contact with the client, especially during conversation. Lean forward to face the client. Nod, smile, or frown to demonstrate agreement or disagreement while listening.

Responses used in U.S. nursing are based on an assessment of the client's needs and are designed to foster growth and establish mutually formulated goals.

NCLEX-PN® exam questions concerning communication are best answered by:

- Conveying respect and warmth, making the client feel accepted and respected as an individual regardless of his or her words, actions, or behavior. This means that the LPN/LVN:
  - Assumes that all client behavior is purposeful and has meaning even though it may not make sense to others
  - Defines the social, physical, and emotional boundaries of the nurse-client relationship
  - Develops a contract with the client
  - Structures time to develop a nurse-client relationship
  - Creates a safe and secure environment
  - Accepts the dependency needs of the client while encouraging, assisting, and supporting movement toward health and independence
  - Intervenes when a client behaves inappropriately to directly reject the behavior but not the client
  - Intervenes directly to respond to the client, not to reinforce an inappropriate behavior
- Demonstrating active listening and genuineness. This means that the LPN/LVN:
  - Asks questions that relate directly to what the client says
  - Maintains good eye contact
  - Leans forward in the chair to face the client
  - Nods, smiles, or frowns to show agreement or disagreement
  - Understands that the personal feelings and past experiences of the nurse can negatively or positively affect relationships with clients

- Communicating interest and empathy by allowing the client to comfortably communicate concerns and behave in new ways. This means that the LPN/LVN:
  - Focuses conversation on the client's feelings
  - Understands that clients respond to the behavioral expectations of the nursing staff
  - Validates the client's feelings
  - Analyzes both verbal and nonverbal behavioral clues
  - Anticipates that there might be some difficulty as the client learns new behaviors

LPN/LVNs create barriers in the communication process when they demonstrate a poor understanding of the basics in therapeutic communication. They must convey respect, warmth, and genuineness through active listening and communicating interest and empathy about the concerns of clients, families, or staff.

Examples of barriers to communication:

- Minimizing concerns
- Giving false reassurance
- Giving approval
- Rejecting the person, not the behavior
- Choosing sides with the client, family member, or staff member in a conflict
- Blaming the external environment for the situation
- Disagreeing or arguing with the client or family member
- Offering advice about a situation
- Pressuring the client or family member for an explanation



- Defending one's own actions or behavior
- Belittling concerns of the client, family member, or staff
- Giving one-word responses to questions
- Using denial
- Interpreting or analyzing both verbal and nonverbal behavioral clues to the client in the situation
- Shifting the focus of the conversation away from the concerns of the client, family member, or staff
- Using jargon or medical terminology without explanation in conversation with the client and/or family
- Invalidating the client's, family member's, or staff's feelings
- Offering unrealistic hope for the future
- Ignoring client clues to help the client set appropriate limits on his or her behavior

The following are some questions that will allow you to practice the right approach.

# Sample Questions

Directions: Carefully read the question and all answer choices. Examine each answer choice and determine whether it is an appropriate response. Indicate your decision in the column labeled “Correct/Incorrect” and give the reason for your choice.

1. A client has been hospitalized for two days for treatment of hepatitis A. When the LPN/LVN enters the client’s room, the client asks the LPN/LVN to leave him alone and stop bothering him. Which of the following responses by the LPN/LVN would be most appropriate?

1. “I understand and will leave you alone for now.”
2. “Why are you angry with me?”
3. “Are you upset because you do not feel better?”
4. “You seem upset this morning.”

2. A client states she is afraid to have her cast removed from her fractured arm. Which of the following is the most appropriate response by the LPN/LVN?

1. "I know it is unpleasant. Try not to be afraid. I will help you."
2. "You seem very anxious. I will stay with you while the cast is removed."
3. "I don't blame you. I'd be afraid also."
4. "My aunt just had a cast removed and she's just fine."

3. A client comes to the clinic because she thinks she is pregnant. She tells the LPN/LVN that she wants the pregnancy terminated because she and her husband do not want to have children, and then begins to cry. Which of the following statements by the LPN/LVN is the most appropriate?

1. "Are you upset because you forgot to use birth control?"
2. "Why are you so upset? You're married. There's no reason not to have the baby."
3. "If you're so upset, why don't you have the baby and put it up for adoption?"
4. "You seem upset. Let's talk about how you're feeling."

4. A client is in the terminal stages of carcinoma of the lung. A family member asks the LPN/LVN, "How much longer will it be?" Which of the following responses by the LPN/LVN would be most appropriate?

1. "I cannot say exactly. What are your concerns at this time?"
2. "I don't know. I'll call the doctor."
3. "This must be a terrible situation for you."
4. "Don't worry, it will be very soon."

5. A client is admitted to the hospital with a diagnosis of bipolar disorder. The man approaches the nurse and says, "Hi, baby," and opens his robe, under which he is naked. Which of the following comments by the LPN/LVN would be most appropriate?

1. "This is inappropriate behavior. Please close your robe and return to your room."
2. "Please dress in your clothes and then join us for lunch in the dining room."
3. "I am offended by your behavior and will have to report you."
4. "Do you need some assistance dressing today?"

6. A client is placed in Buck's traction. The LPN/LVN assigned to her prepares to assist her with a bath. The woman says, "You're too young to know how to do this. Get me somebody who knows what they're doing." Which of the following responses by the LPN/LVN would be most appropriate?

1. "I am young, but I graduated from nursing school."
2. "If I don't bathe you now, you'll have to wait until I'm finished with my other clients."
3. "Can you be more specific about your concerns?"
4. "Your concerns are unnecessary. I know what I'm doing."

7. A client is admitted to the hospital with an abdominal mass and is scheduled for an exploratory laparotomy. She asks the LPN/LVN admitting her, "Do you think I have cancer?" Which of the following responses by the LPN/LVN would be most appropriate?

1. "Would you like me to call your doctor so that you can discuss your specific concerns?"
2. "Your tests show a mass. It must be hard not knowing what is wrong."
3. "It sounds like you are afraid that you are going to die from cancer."
4. "Don't worry about it now; I'm sure you have many healthy years ahead of you."

8. A client is admitted to the postpartum unit following a miscarriage. The next day the LPN/LVN finds the woman crying while looking at the babies in the newborn nursery. Which of the following approaches by the LPN/LVN would be most appropriate?

1. Assure the woman that the loss was “for the best.”
2. Explain to her that she is young enough to have more children.
3. Ask her why she is looking at the babies.
4. Acknowledge the loss and be supportive.

9. An elderly client is hospitalized with major neurocognitive disorder (NCD) due to Alzheimer’s disease. His daughter tells the LPN/LVN that caring for him is too hard, but that she feels guilty placing him in a nursing home. Which of the following statements by the LPN/LVN is most appropriate?

1. “It is hard to be caught between taking care of your needs and your father’s needs.”
2. “Would you like me to help you find a nursing home?”
3. “Don’t feel guilty. The only solution is to place your father in a nursing home.”
4. “I think I would feel guilty too if I had to place my father in a nursing home.”

# Answers and Explanations

## Sample Questions

1. “You seem upset this morning” is the correct answer choice because the LPN/LVN seeks to verbally validate the client’s behavior rather than simply respond to the behavior. This response promotes the nurse-client relationship by encouraging the client to share his feelings with the LPN/LVN.

“I understand and will leave you alone for now” is not the best approach because it does not promote further communication between the LPN/LVN and the client about how the client is feeling. In order to interpret this client’s behavior, the LPN/LVN must first validate it with the client.

“Why are you angry with me?” is incorrect. The LPN/LVN is drawing a conclusion about the client’s behavior. This type of action is too confrontational. “Why” questions are considered nontherapeutic.

“Are you upset because you do not feel better?” is not the best choice. The LPN/LVN is drawing a conclusion about the client’s behavior without validating it first. This type of response may also belittle the client’s actual concerns.

2. “You seem very anxious. I will stay with you while the cast is removed” is the best response because the LPN/LVN responds to the client’s feelings of fear. This is consistent with therapeutic

communication used in American nursing. This response also provides an additional opportunity for the LPN/LVN to remain with the client in a supportive capacity enhancing the nurse-client relationship.

“I know it is unpleasant. Try not to be afraid. I will help you” is not the best response. It is not clear what concerns the client has about this procedure. The LPN/LVN should establish this before responding. The LPN/LVN falsely reassures the client by saying, “I will help you.” Because you do not know the nature of the client’s concerns, you cannot honestly offer help.

“I don’t blame you. I’d be afraid also” is not the correct response because the LPN/LVN shifts the focus of the conversation from the client to the LPN/LVN. This sets up a barrier to further communication. The LPN/LVN concedes the issue too quickly, leaving the source of the client’s fear unknown.

“My aunt just had a cast removed and she’s just fine” is not the best choice. The focus of the conversation is shifted from the client to the LPN/LVN’s aunt, who is of no concern to the client. This response fails to explore the source of the client’s anxiety and sets up a block to further communication.

3. “You seem upset. Let’s talk about how you’re feeling” is the best answer to this question. This promotes the nurse-client relationship and illustrates therapeutic communication used in American nursing. The LPN/LVN responds to the client’s feelings in a nonjudgmental, empathetic way.

“Are you upset because you forgot to use birth control?” is inappropriate because it places blame on the client. The LPN/LVN should not assume that the client “forgot” to do something. This



response also fails to respond to the client's feelings and does not encourage the client to discuss her concerns.

"Why are you so upset? You're married. There's no reason not to have the baby" is inappropriate in terms of American therapeutic communication. This response is harsh and presumptive, and assumes that the purpose of every marriage is to have children. This is not always the case in American culture. With this response, the LPN/LVN does not attempt to verify the reason for the client's tears, thereby discouraging further conversation about what the client is actually experiencing.

"If you're so upset, why don't you have the baby and put it up for adoption?" is also inappropriate. This is a value-laden assumption placing positive value on adoption. Again, the LPN/LVN fails to explore with the client the reason for the client's tears, thereby discouraging further communication. The LPN/LVN is also offering advice.

4. "I cannot say exactly. What are your concerns at this time?" is the most appropriate response because it is unclear why the family member has approached the LPN/LVN at this point. Perhaps the client is in pain and the family member wants to discuss it with the LPN/LVN. This response allows for that possibility. This response is also direct and factually correct.

"I don't know. I'll call the doctor" is not the most appropriate response. It shifts the focus of responsibility from the LPN/LVN to the physician, which prevents a nurse-family member relationship from developing.

"This must be a terrible situation for you" is not the most appropriate response. It is a value-laden statement that fails to

explore the family member's reason for approaching the LPN/LVN.

"Don't worry, it will be very soon" is inappropriate because the LPN/LVN offers the family member false reassurance. It also offers advice by telling the family member not to worry. This statement is demeaning and may sound as if the nurse is too busy to discuss the family member's concerns.

5. "This is inappropriate behavior. Please close your robe and return to your room" is the correct answer choice. This statement by the LPN/LVN responds to the client's behavior, sets limits on the behavior, and directs the client toward more appropriate social behavior in the milieu. This statement rejects the client's behavior, not the client as a person.

"Please dress in your clothes and then join us for lunch in the dining room" is incorrect. It ignores the behavior of the client exposing himself. Instead it directs the client to dress and report to the dining room for lunch as though nothing has happened. This is inappropriate and nontherapeutic.

"I am offended by your behavior and will have to report you" is incorrect. It shifts the focus from the client to the LPN/LVN and the LPN/LVN's feelings. The LPN/LVN's personal feelings are irrelevant. Also, the LPN/LVN goes on to threaten the client with reporting him. This is nontherapeutic.

"Do you need some assistance dressing today?" is incorrect. This question fails to respond to the client's behavior. It is also a yes/no question, which is nontherapeutic.

6. "Can you be more specific about your concerns?" is the correct answer. This is the best answer choice because it seeks to validate the

client's message. It is direct, is not defensive, and allows the client to express her point of view.

"I am young, but I graduated from nursing school" is incorrect. It responds to only part of the message that the client sent to the LPN/LVN. It assumes that the LPN/LVN knows what the client's concerns are and agrees that there is some problem associated with being too young. Further clarification is necessary in this situation.

"If I don't bathe you now, you'll have to wait until I'm finished with my other clients" is a nontherapeutic response. It fails to explore the client's concerns about the LPN/LVN. It is an uncaring and punitive statement by the LPN/LVN that is inappropriate in a nurse-client relationship.

"Your concerns are unnecessary. I know what I'm doing" is incorrect. The LPN/LVN dismisses the client's concerns by telling her that she shouldn't be concerned. The LPN/LVN should not tell a client how he or she should be feeling. It may sound as if the LPN/LVN is trying to reassure the client by telling her that the LPN/LVN knows what he or she is doing; however, the LPN/LVN has yet to validate the concerns that underlie the client's statement.

7. "Your tests show a mass. It must be hard not knowing what is wrong" is the correct answer choice. This is the best answer choice because it responds to the client's feelings. It allows the client to continue to identify and express her concerns regarding surgery, hospitalization, and the possibility of having a potentially life-threatening illness. The LPN/LVN validates that the client has appropriate concerns and invites her to elaborate on them.

"Would you like me to call your doctor so that you can discuss your specific concerns?" This response is incorrect because it shifts the

focus of responsibility from the LPN/LVN to the doctor, thereby reducing the possibility of developing an ongoing nurse-client relationship.

“It sounds like you are afraid that you are going to die from cancer” is inappropriate. It fails to validate with the client that “dying from cancer” is in fact the issue. The LPN/LVN inappropriately concludes this on the basis of a brief statement made by the client without giving the client a chance to elaborate.

“Don’t worry about it now; I’m sure that you have many healthy years ahead of you” is inappropriate. The LPN/LVN is telling the client how she should feel and then goes on to offer false reassurance. This response fails to address or explore the actual concerns of the client.

8. “Acknowledge the loss and be supportive” is the best answer choice. It promotes the nurse-client relationship and allows for the identification of feelings and the expression of sadness. The client is in an acute stage of grief. This type of response addresses this issue.

“Assure the woman that the loss was ‘for the best’ is incorrect. This statement is insensitive to the client, offers false reassurance, and belittles the client’s most immediate concerns.

“Explain to her that she is young enough to have more children” is inappropriate because it is insensitive to the grief that the client is experiencing. The LPN/LVN offers false reassurance by telling the woman that she can have other children.

“Ask her why she is looking at the babies” is also incorrect. This is inappropriate because it is a “why” question and because the woman may become defensive when answering such a question. This response also fails to respond to the client’s immediate grief.

9. “It is hard to be caught between taking care of your needs and your father’s needs” is the correct response. This is the most therapeutic response as it allows for continued development of a relationship with the family member of the client. This response allows the LPN/LVN to explore and validate the daughter’s feelings about the nursing home placement.

“Would you like me to help you find a nursing home?” is not the best answer choice. It is a yes/no question and doesn’t encourage discussion of the daughter’s feelings.

“Don’t feel guilty. The only solution is to place your father in a nursing home” is not the best therapeutic response. The daughter’s concerns are minimized when the LPN/LVN tells the daughter not to worry. While it may be true that the daughter has done all that she can, this response cuts off an opportunity for further conversation with the LPN/LVN.

“I think I would feel guilty too if I had to place my father in a nursing home” is also incorrect. This statement is value-laden and judgmental, and could block further communication between the LPN/LVN and the client’s daughter. It is not important what the LPN/LVN thinks about the daughter’s decision, nor is it the LPN/LVN’s role to make the daughter feel more guilty about her decision.



# Language

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English is the predominant language spoken and written in the United States, and the NCLEX-PN® exam is administered only in English. With the exception of the medical terminology, the reading level of the NCLEX-PN® exam is that of a sophomore in an American high school. In order to be successful on the NCLEX-PN® exam, you must understand English—and the terminology—as it is used in the United States.

## Vocabulary

Vocabulary can be a challenge for international nurses on the NCLEX-PN® exam. Not only must you know what each word means, but sometimes a word may have more than one meaning. You need to be able to correctly identify words as they are used in context. Refer to the NCLEX-PN® Exam Resources section in the back of this book for some of the commonly found words on the NCLEX-PN® exam. Some other ways to increase your vocabulary and learn how the words are used in everyday English include:

- Talking with Americans
- Watching American movies and television
- Reading American newspapers and magazines

## Abbreviations

Many of you are unfamiliar with the abbreviations used in the United States. When studying, always look up unknown words in a medical dictionary. Consult Appendix C for a list of abbreviations used by nurses in American health care settings.

As an internationally educated nurse, you face special challenges in preparing for the NCLEX-PN® exam. Following the tips and guidelines outlined in this book will increase your chances of passing the NCLEX-PN® exam and will allow you to reach your career goals.



# Kaplan Programs for International Nurses

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Knowing something about U.S. culture and how U.S. nurses fit into the overall health care industry is important for nurses trained outside the United States. If you are not from the United States but are interested in learning more about U.S. nursing, wish to practice in the United States, or are exploring the possibilities of attending a U.S. nursing school for graduate study, Kaplan is able to help you.

## CGFNS<sup>®</sup> (Commission on Graduates of Foreign Nursing Schools) Preparation for International Nurses

Many U.S. state boards of nursing require internationally educated nurses to obtain a CGFNS<sup>®</sup> certificate before applying for initial licensure as an LPN/LVN. The certification process requires that a candidate pass a two-part test of nursing knowledge and demonstrate English language proficiency on the TOEFL<sup>®</sup> exam. Kaplan offers a comprehensive course of study to help you pass this exam. To obtain information, please call 1-800-527-8378. Outside the United States, please call 1-212-997-5883 or log on to the website at [kaplannursing.com](http://kaplannursing.com).



## Preparation for the NCLEX-PN® Examination for International Nurses

An internationally educated nurse must pass the NCLEX-PN® exam in order to obtain a license to practice as an LPN/LVN in the United States. Kaplan has a comprehensive course and review products to help international nurses pass this exam. To obtain information, please call 1-800-527-8378 (outside the United States: 1-212-997-5883) or log on to the website at <https://www.kaptest.com/ispn-cgfnscourses/ispn-cgfnscprep>.

## Kaplan English Programs

In addition to Kaplan Nursing programs, Kaplan also offers English programs to help you improve your English skills and score on the TOEFL® exam. Kaplan's English programs are designed to help students and professionals from outside the United States meet their educational and career goals. At locations throughout the United States, international students take advantage of Kaplan's programs to help them improve their academic and conversational English skills, raise their scores on the TOEFL® and other standardized exams, and gain admission to the schools of their choice. Our staff and instructors give international students the individualized instruction they need to succeed. The following sections provide brief descriptions of some of Kaplan's programs for non-native English speakers.

## English Language Programs

Kaplan offers a wide range of English language programs to help you improve your English quickly and effectively, regardless of your current level. Each of our programs has a special focus, allowing you to direct your study in a way that suits your particular language needs. All of the essential language skills are covered, and your fluency and confidence will increase rapidly thanks to Kaplan's communicative teaching method.

## TOEFL® and Academic English

Kaplan has updated its world-famous TOEFL® course to prepare students for the TOEFL® iBT. Designed for high-intermediate to advanced-level English speakers, our course focuses on the academic English skills you will need to succeed on the test. The course includes TOEFL®-focused reading, writing, listening, and speaking instruction and hundreds of practice items similar to those on the exam. Kaplan's expert instructors help you prepare for the four sections of the TOEFL® iBT, including the Speaking section. Our simulated online TOEFL® tests help you monitor your progress and provide you with feedback on areas where you require improvement. We will teach you how to get a higher score!

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## Applying to Kaplan English Programs\*

To get more information, or to apply for admission to any of Kaplan's programs for non-native English speakers, contact us at:

Kaplan English Programs

Phone: 1-800-818-9128 (within the United States)

Phone: +44 (0) 20 7045 5000 (elsewhere)

Website: [kaplaninternational.com](http://kaplaninternational.com)

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PART 4

THE PRACTICE TEST

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# Practice Test

Directions: Each question or incomplete statement below is followed by four suggested answers or completions. In each case, HIGHLIGHT the statement that best answers the question or completes the statement. Allot 3 hours of uninterrupted time to take the practice test.

1. The LPN/LVN is gathering data from a client who is receiving treatment for obsessive-compulsive disorder (OCD). Which of the following is the most important question the LPN/LVN should ask this client?
  - (A) “Do you find yourself forgetting simple things?”
  - (B) “Do you find it difficult to focus on a given task?”
  - (C) “Do you have trouble controlling upsetting thoughts?”
  - (D) “Do you experience feelings of panic in a closed area?”
  
2. The LPN/LVN is caring for a client who states, “I just want to die.” The LPN/LVN should examine the client’s medical record for which of the following documents?

- (A) Advance directives.
- (B) Power of attorney.
- (C) “Do not resuscitate” order.
- (D) Living will.

3. A newly admitted client with a history of seizures suddenly says to the LPN/LVN, “I hear drums.” Which of the following should the LPN/LVN do first?

- (A) Tell the client to ignore the drums.
- (B) Place client in a darkened room away from nurses’ station.
- (C) Continue to question the client about the drum sound.
- (D) Insert an oral airway in the client.

4. A client diagnosed with multiple myeloma is admitted to the unit after developing pneumonia. When the LPN/LVN enters the client’s room wearing a mask, the client says, in an irritated tone of voice, “Why are you wearing that mask?” Which of the following responses by the LPN/LVN is best?

- (A) “The chest x-ray taken this morning indicates you have pneumonia.”
- (B) “What have you been told about the x-rays that were taken this morning?”
- (C) “You have been placed on contact precautions due to your infection.”
- (D) “I am trying to protect you from the germs in the hospital.”

5. A nursing team consists of an RN, an LPN/LVN, and a unlicensed assistive personnel (UAP). The LPN/LVN should be assigned to which of the following clients?

- (A) A client with a diabetic ulcer that requires a dressing change.
- (B) A client diagnosed with cancer who is reporting bone pain.
- (C) A client with terminal cancer being transferred to hospice home care.
- (D) A client with a fracture of the right leg who asks to use the urinal.

6. To determine the structural relationship of one hospital department with another, the LPN/LVN should consult which of the following?

- (A) Organizational chart.
- (B) Job descriptions.
- (C) Personnel policies.
- (D) Procedures manual.

7. A client reports pain in the right lower extremity. The primary health care provider prescribes codeine 60 mg and aspirin grains X PO every 4 hours, as needed for pain. Each codeine tablet contains 15 mg of codeine. Each aspirin tablet contains 325 mg of aspirin. Which of the following should the LPN/LVN administer?

- (A) 2 codeine tablets and 4 aspirin tablets.
- (B) 4 codeine tablets and 3 aspirin tablets.
- (C) 4 codeine tablets and 2 aspirin tablets.
- (D) 3 codeine tablets and 3 aspirin tablets.

8. The LPN/LVN is caring for a client receiving paroxetine. It is most important for the LPN/LVN to report which of the following to the primary health care provider?

- (A) The client reports no appetite change.
- (B) The client reports recently being started on digoxin.
- (C) The client reports applying sunscreen to go outdoors.
- (D) The client reports driving the car to work.

9. A client with a “do not resuscitate” order experiences a cardiac arrest. Which of the following is the first action the LPN/LVN should take?

- (A) Administer lifesaving medications.
- (B) Assess the client for signs of death.
- (C) Open the airway and give 2 breaths.
- (D) Summon the emergency code team.

10. An LPN/LVN is working in the newborn nursery. Which of the following client-care assignments should the LPN/LVN question?



- (A) A 2-day-old client lying quietly alert with a heart rate of 185 beats/minute.
- (B) A 1-day-old client who is crying and has a bulging anterior fontanel.
- (C) A 12-hour-old client whose respirations are 45 breaths/minute and irregular while being held.
- (D) A 5-hour-old client whose hands and feet appear blue bilaterally while sleeping.

11. The LPN/LVN is inserting a nasogastric (NG) tube. The LPN/LVN should use which of the following personal protective equipment during NG tube insertion?

- (A) Gloves, gown, goggles, and surgical cap.
- (B) Sterile gloves, mask, and gown.
- (C) Gloves, gown, mask, and goggles.
- (D) Double gloves, goggles, mask, and surgical cap.

12. The LPN/LVN is caring for clients in the outpatient clinic. Which of the following clients should the LPN/LVN see first?

- (A) A client with hepatitis A who states, "My arms and legs are itching."
- (B) A client with a cast on the right leg who states, "I have a funny feeling in my right leg."
- (C) A client with osteomyelitis of the spine who states, "I am so nauseous that I can't eat."
- (D) A client with rheumatoid arthritis who states, "I am having trouble sleeping."

13. Which of the following client assignments should an LPN/LVN question?

- (A) A client with a chest tube who is ambulating in the hallway.
- (B) A client with a colostomy who requires colostomy irrigation assistance.
- (C) A client with a right-sided stroke who requires assistance with bathing.
- (D) A client who is refusing medication to treat cancer of the colon.

14. The LPN/LVN is caring for a client with hepatitis B. The client is to be discharged the next day. The LPN/LVN would be most concerned if the client made which of the following statements?

- (A) "I must not share eating utensils with my family members."
- (B) "I must use my own bath towel."
- (C) "I'm glad I can have intimate relations with my partner."
- (D) "I must eat small, frequent meals."

15. The LPN/LVN is carrying out the plan for care of a client with anemia who reports weakness. Which of the following tasks could be assigned to the unlicensed assistive personnel (UAP)?

- (A) Auscultate the client's breath sounds.
- (B) Set up the client's lunch tray.
- (C) Obtain client's dietary history.
- (D) Instruct client how to balance rest and activity.

16. The LPN/LVN on the surgical floor is receiving hand-off report from the RN. Which of the following clients should the LPN/LVN see first?
- (A) A client admitted 3 days ago with a gunshot wound; 1.5-cm area of dark drainage noted on the dressing.
  - (B) A client who had a mastectomy 2 days ago; 23 mL of serosanguinous fluid noted in the wound drain.
  - (C) A client with a collapsed lung due to an accident; no drainage noted in the previous 8 hours.
  - (D) A client who had an abdominal-perineal resection 3 days ago; client now reports chills.
17. A client scheduled for a cardiac catheterization says to the LPN/LVN, "I know you were in here when I signed the consent form for the test. I thought I understood everything, but now I'm not so sure." Which of the following responses by the LPN/LVN is best?
- (A) "Why didn't you listen more closely to the explanation?"
  - (B) "You sound as if you would like to ask more questions."
  - (C) "I'll get you a pamphlet about cardiac catheterization."
  - (D) "That often happens during explanation of this procedure."
18. A 1-day-old client diagnosed with intrauterine growth retardation has a high-pitched shrill cry and appears restless and irritable. The LPN/LVN also observes fist-sucking behavior. Based on this data, which of the following actions should the LPN/LVN take first?

- (A) Gently massage the client's back every 2 hours.
- (B) Tightly swaddle the client in a flexed position.
- (C) Schedule feeding times every 3 to 4 hours.
- (D) Encourage eye contact with the client during feedings.

19. The LPN/LVN visits a neighbor who is at 20 weeks' gestation. The neighbor reports nausea, headache, and blurred vision. The LPN/LVN notes that the neighbor has tremors and appears nervous and diaphoretic. It would be most important for the LPN/LVN to ask which of the following questions?

- (A) "Are you having menstrual-like cramps?"
- (B) "When did you last eat or drink?"
- (C) "Have you been diagnosed with diabetes?"
- (D) "Have you been lying on the couch?"

20. The LPN/LVN notes that a client newly admitted to the pediatric unit is scratching the head almost constantly. It would be most important for the LPN/LVN to take which of the following actions?

- (A) Discuss basic hygiene with the parents.
- (B) Instruct the child not to sleep with the dog.
- (C) Advise parents to contact an exterminator.
- (D) Observe the scalp for small white specks.

21. The client diagnosed with major depressive disorder who was admitted to the psychiatric unit for treatment and observation a

week ago suddenly appears cheerful and motivated. The LPN/LVN should be aware of which of the following?

- (A) The client is likely sleeping well because of the medication.
- (B) The client has made new friends and has a support group.
- (C) The client may have finalized a suicide plan.
- (D) The client is no longer depressed due to treatment.

22. The LPN/LVN is caring for a client reports an off-white vaginal discharge with a curdlike appearance. The LPN/LVN observes the discharge and vulvular erythema. It would be most important for the LPN/LVN to ask which of the following questions?

- (A) "Do you routinely douche?"
- (B) "Are you sexually active?"
- (C) "What kind of birth control do you use?"
- (D) "Have you taken any cough medicine?"

23. The primary health care provider orders application of an elastic wrap bandage for a client's left leg from toes to mid-thigh. The LPN/LVN should do which of the following?

- (A) Increase friction between skin and bandage surfaces.
- (B) Leave a small distal portion of the extremity exposed.
- (C) Use multiple pins to secure the bandage.
- (D) Position the left leg in abduction.

24. A client recovering from a laparoscopic laser cholecystectomy says to the LPN/LVN, "I hate the thought of eating a low-fat diet for the

rest of my life.” Which of the following responses by the LPN/LVN is most appropriate?

- (A) “I will ask the dietician to come speak with you.”
- (B) “What do you think is so bad about following a low-fat diet?”
- (C) “It may not be necessary for you to follow a low-fat diet for that long.”
- (D) “At least you will be alive and not suffering that pain.”

25. The LPN/LVN is caring for clients in a pediatric clinic. The mother of a 14-year-old male privately tells the LPN/LVN that she is worried about her son because she unexpectedly walked into his bedroom and discovered him masturbating. Which of the following responses by the LPN/LVN is most appropriate?

- (A) “Tell your son he could go blind doing that.”
- (B) “Masturbation is a normal part of sexual development.”
- (C) “He’s really too young to be masturbating.”
- (D) “Why don’t you give him more privacy?”

26. A client begins to breathe very rapidly. Which of the following actions by the LPN/LVN would be the most appropriate?

- (A) Auscultate the client's apical pulse rate.
- (B) Measure client's blood pressure and pulse.
- (C) Notify the primary health care provider.
- (D) Obtain the client's oxygen saturation level.

27. The LPN/LVN is planning morning care for a client hospitalized after a stroke resulting in left-sided paralysis and homonymous hemianopia. During morning care, the LPN/LVN should do which of the following?

- (A) Provide morning care from the right side of the client.
- (B) Speak loudly and distinctly when talking with the client.
- (C) Reduce the level of lighting in the client's room to prevent glare.
- (D) Provide the client's care to reduce the client's energy expenditure.

28. A primigravid client at 32 weeks' gestation comes to the clinic for her initial prenatal visit. The client reports periodic headaches and continually bumping into things. The LPN/LVN observes numerous bruises in various stages of healing around the client's breasts and abdomen. Vital signs are: BP 120/80, pulse 72 beats/minute, respirations 18 breaths/minute, and fetal heart tones 142 beats/minute. Which of the following responses by the LPN/LVN is best?

- (A) "Are you battered by your partner?"
- (B) "How do you feel about being pregnant?"
- (C) "Tell me about your headaches."
- (D) "You may be more clumsy due to your size."

29. The LPN/LVN is providing care for a client with chronic obstructive pulmonary disease (COPD) who is receiving oxygen through a nasal

cannula. The LPN/LVN should expect which of the following to occur?

- (A) Arterial blood gases will be analyzed every 2 hours.
- (B) The client's oral intake will be restricted.
- (C) The client will be maintained on bed rest.
- (D) The oxygen flow rate will be set at 3 L/minute or less.

30. The LPN/LVN is caring for a pediatric client in a leg cast for treatment of a right ankle fracture. It is most important for the LPN/LVN to reinforce which of the following activities after discharge?

- (A) The client performs isometric exercises of the right leg.
- (B) The parent massages the client's right foot with moisturizer.
- (C) The parent cleans the leg cast with mild soap and water.
- (D) The parent elevates the right leg on several pillows.

31. The LPN/LVN is caring for a client who had a thyroidectomy 12 hours ago for treatment of Graves' disease. The LPN/LVN would be most concerned if which of the following were observed?



- (A) The client's vital signs include: blood pressure 138/82 mm Hg, pulse 84 beats/minute, and respirations 16 breaths/minute.
- (B) The client supports the head and neck to turn head to right.
- (C) The client spontaneously flexes the wrist when the blood pressure cuff is inflated during blood pressure measurement.
- (D) The client becomes drowsy and reports a sore throat.

32. A client is admitted who reports severe pain in the right lower quadrant of the abdomen. Which of the following actions should the LPN/LVN take to assist the client with pain relief?

- (A) Encourage rhythmic, shallow breathing.
- (B) Massage the right lower quadrant of the abdomen.
- (C) Apply a warm heating pad to the client's abdomen.
- (D) Position client for comfort using pillows.

33. Which of the following actions by the LPN/LVN would be considered negligence?

- (A) Administering heparin subcutaneously into a client's abdomen without first aspirating for blood.
- (B) Crushing furosemide and adding to a teaspoon of applesauce for an elderly client.
- (C) Lowering the bed side rails after administering meperidine and hydroxyzine to a client preoperatively.
- (D) Placing a used syringe and needle in a sharps container in a client's room.

34. The LPN/LVN is teaching an elderly client with right-sided weakness how to use a cane. Which of the following behaviors by the client indicates that the teaching was effective?

- (A) The client holds the cane with the right hand, moves the cane forward followed by the right leg, and then moves the left leg.
- (B) The client holds the cane with the right hand, moves the cane forward followed by the left leg, and then moves the right leg.
- (C) The client holds the cane with the left hand, moves the cane forward followed by the right leg, and then moves the left leg.
- (D) The client holds the cane with the left hand, moves the cane forward followed by the left leg, and then moves the right leg.

35. The LPN/LVN is caring for client whose vital signs have been within normal limits. Now vital signs include: tympanic temperature 103.6° F (39.7° C), pulse 82 beats/minute, regular and strong, respirations 14 breaths/minute, shallow and unlabored, and blood pressure 134/88 mm Hg. What should the LPN/LVN's next action be?

- (A) Notify primary health care provider immediately.
- (B) Proceed with the client's care.
- (C) Record vital signs in medical record.
- (D) Retake the temperature with different thermometer.

36. A client admitted to the hospital with right femur fracture is placed in balanced suspension traction with a Thomas splint and Pearson attachment. During the first 48 hours, the LPN/LVN should gather data related to which of the following complications?

- (A) Pulmonary embolism.
- (B) Fat embolism.
- (C) Avascular necrosis.
- (D) Bone malunion.

37. The LPN/LVN is helping an unlicensed assistive personnel (UAP) provide a bed bath to a comatose client who is incontinent. The LPN/LVN should intervene if which of the following actions is noted?

- (A) The UAP answers the phone while wearing gloves.
- (B) The UAP log-rolls the client to provide back care.
- (C) The UAP places an incontinence pad under the client.
- (D) The UAP positions client on the left side, head elevated.

38. A client is brought to the emergency department for treatment after being found on the floor by a family member. When comparing the legs, the LPN/LVN would most likely make which of the following observations?

- (A) The client's left leg is longer than the right leg and externally rotated.
- (B) The client's left leg is shorter than the right leg and internally rotated.
- (C) The client's left leg is shorter than the right leg and adducted.
- (D) The client's left leg is longer than the right leg and is abducted.

39. The LPN/LVN is caring for a client with a cast on the left leg. The LPN/LVN would be most concerned if which of the following is observed?

- (A) Capillary refill time is less than 3 seconds.
- (B) Client reports discomfort and itching.
- (C) Client reports tightness and pain.
- (D) Client's foot is elevated on a pillow.

40. The LPN/LVN is assisting with discharging a client from an inpatient alcohol treatment unit. Which of the following statements by the client's wife indicates that the family is coping adaptively?

- (A) "My husband will do well as long as I keep him engaged in activities that he likes."
- (B) "My focus is learning how to live my life."
- (C) "I am so glad that our problems are behind us."
- (D) "I'll make sure that the children don't give my husband any problems."

41. An LPN/LVN is caring for clients in the mental health clinic. A client reporting insomnia and anorexia tearfully tells the LPN/LVN about a personal job loss after 15 years of employment with the company. Which of the following responses by the LPN/LVN is most appropriate?

- (A) "Did you receive a severance package?"
- (B) "Focus on your healthy, happy family."
- (C) "Explain what happened with your job."
- (D) "Job loss is very common these days."

42. A client with a history of alcohol use disorder is transferred to the unit in an agitated state. The client is vomiting and diaphoretic, and states that it has been 5 hours since the last drink. The LPN/LVN would expect to administer which of the following medications?

- (A) Chlordiazepoxide.
- (B) Disulfiram.
- (C) Methadone.
- (D) Naloxone.

43. The LPN/LVN is caring for a client diagnosed with end-stage colon cancer. The spouse of the client says, "We have been married for so long. I am not sure how I can go on now." What is the most appropriate response by the LPN/LVN?

- (A) "It sounds like your children will be there to help during your time of grieving."
- (B) "I know this is difficult. Tell me more about what you are feeling now."
- (C) "Think about the pain and suffering your spouse has endured lately."
- (D) "I will call the hospice nurse to discuss to your spouse's condition with you."

44. The LPN/LVN is reinforcing teaching with an elderly client about how to use a standard aluminum walker. Which of the following behaviors by the client indicates that the reinforcement of teaching was effective?

- (A) The client slowly pushes the walker forward 12 inches (30 cm), then takes small steps forward while leaning on the walker.
- (B) The client lifts the walker, moves it forward 10 inches (25 cm), and then takes several small steps forward.
- (C) The client supports weight on the walker while advancing it forward, then takes small steps while balancing on the walker.
- (D) The client slides the walker 18 inches (46 cm) forward, then takes small steps while holding onto the walker for balance.

45. An LPN/LVN is providing care for a group of elderly clients in a long-term care facility. The LPN/LVN knows that the elderly are at greater risk of developing sensory deprivation for which of the following reasons?

- (A) Increased sensitivity to the side effects of medications.
- (B) Decreased visual, auditory, and gustatory abilities.
- (C) Isolation from their families and familiar surroundings.
- (D) Decreased musculoskeletal function and mobility.

46. The LPN/LVN would expect which of the following clients to be able to sign a consent form for nonemergent medical treatment?

- (A) A school-age child with a right tibia and fibula fracture.
- (B) A client requiring surgery for acute appendicitis.
- (C) A client who is confused after a motor vehicle accident.
- (D) A client who has been legally declared incompetent.

47. An LPN/LVN is assisting with the discharge of a client with a diagnosis of hepatitis of unknown etiology. The LPN/LVN knows that teaching has been successful if the client makes which of the following statements?

- (A) "I am so sad that I am not able to hold my baby."
- (B) "I will eat my meal after my family finishes eating."
- (C) "I will make sure that my children don't use my eating utensils."
- (D) "I'm glad that I don't have to get help taking care of my children."

48. The LPN/LVN checks the IV flow rate for a postoperative client. The client is to receive 3,000 mL of lactated Ringer's lactate solution IV infused over 24 hours. The IV administration set has a drop factor of

10 drops per milliliter. The LPN/LVN would expect the client's IV to infusing at how many drops per minute?

- (A) 18.
- (B) 21.
- (C) 35.
- (D) 40.

49. A client diagnosed with emphysema becomes restless and confused. Which of the following actions should the LPN/LVN take next?

- (A) Encourage pursed-lip breathing.
- (B) Measure the client's temperature.
- (C) Assess the client's potassium level.
- (D) Increase oxygen flow rate to 5 L/minute.

50. The LPN/LVN is caring for a client following cataract surgery on the right eye. The client reports severe eye pain in the right eye. Which of the following activities should the LPN/LVN do first?

- (A) Administer an analgesic to the client.
- (B) Recheck the client's condition in 30 minutes.
- (C) Document finding in client's medical record.
- (D) Report the finding to the supervising RN.

51. The LPN/LVN is caring for a client 4 hours after intracranial surgery. Which of the following actions should the LPN/LVN take immediately?



- (A) Instruct the client to deep breathe, cough, and expectorate into a tissue.
- (B) Position the client in a left lateral position with neck flexed.
- (C) Perform passive range-of-motion exercises every two hours.
- (D) Use a turning sheet under the client's head to midhigh to reposition in bed.

52. A pediatric client with a congenital heart disorder is admitted with heart failure. Digoxin 0.12 mg by mouth daily is prescribed for the client. The bottle contains 0.05 mg of digoxin in 1 mL of solution. Which of the following amounts should the LPN/LVN administer to the client after validating the dose with the RN?

- (A) 1.2 mL.
- (B) 2.4 mL.
- (C) 3.5 mL.
- (D) 4.2 mL.

53. The LPN/LVN is caring for a client diagnosed with chronic lymphocytic leukemia, hospitalized for treatment of hemolytic anemia. The LPN/LVN should expect to implement which of the following actions?

- (A) Encourage activities with other clients in the day room.
- (B) Isolate the client from visitors and clients to avoid infection.
- (C) Provide a diet that contains foods that are high in vitamin C.
- (D) Maintain a quiet environment to promote adequate rest.

54. The LPN/LVN is caring for a client with cervical cancer. The LPN/LVN notes that the radium implant has become dislodged. Which of the following actions should the LPN/LVN take first?

- (A) Grasp the implant with a sterile hemostat and carefully reinsert it into the client.
- (B) Wrap the implant in a blanket and place it behind a lead shield until reimplantation.
- (C) Ensure the implant is picked up with long-handled forceps and placed in a lead container.
- (D) Obtain a dosimeter reading on the client and report it to the primary health care provider.

55. The LPN/LVN comes to the home of a client with cellulitis of the left leg to perform a daily dressing change. The client tells the LPN/LVN that the unlicensed assistive personnel (UAP) changed the dressing earlier that morning. Which of the following actions by the LPN/LVN is best?

- (A) Tell client that the new dressing looks fine.
- (B) Notify the RN supervisor of the situation.
- (C) Ask the client to describe the dressing change.
- (D) Report the UAP to the home care agency.

56. The LPN/LVN is caring for a client with pernicious anemia. The LPN/LVN reinforces teaching about the plan of care. The LPN/LVN should report which of the following statements to the RN?

- (A) "In order to get better, I will take iron pills."
- (B) "I will attend smoking cessation classes."
- (C) "I will learn how to perform IM injections."
- (D) "I will make sure to eat a well-balanced diet."

57. The LPN/LVN is caring for clients on a general medical/surgical unit of an acute care facility. Four clients have been admitted in the last 20 minutes. Which of the admissions should the LPN/LVN see first?

- (A) A client reporting vomiting and diarrhea.
- (B) A client with third-degree burns to face.
- (C) A client with a fractured left hip.
- (D) A client reporting epigastric pain.

58. The LPN/LVN is caring for a client with a diagnosis of chronic bronchitis. The client has audible wheezing, and an oxygen saturation of 85%. Four hours ago, the oxygen saturation was 88%. It is most important for the LPN/LVN to take which of the following actions?

- (A) Give beclomethasone, 2 puffs via metered-dose inhaler.
- (B) Auscultate the client's bilateral breath sounds.
- (C) Increase oxygen flow rate to 4 L/minute via mask.
- (D) Administer albuterol, 2 puffs via metered-dose inhaler.

59. The LPN/LVN is caring for a client hospitalized for observation following a fall. The client states, "My friend fell last year, and no one thought anything was wrong. She died 2 days later!" Which of the following responses by the LPN/LVN is best?

- (A) "This happens to quite a few people."
- (B) "We are monitoring you, so you'll be okay."
- (C) "Don't you think I'm taking good care of you?"
- (D) "You're concerned that it might happen to you?"

60. The LPN/LVN is caring for clients on the pediatric unit. A client with second- and third-degree burns on the right thigh is being admitted. The LPN/LVN should expect the new client to be placed with which one of the following roommates?

- (A) A client with chickenpox.
- (B) A client with asthma.
- (C) A client who developed acute diarrhea after antibiotic.
- (D) A client with methicillin-resistant *Staphylococcus aureus*.

61. To evaluate the effectiveness of a client's heparin therapy, the LPN/LVN should monitor which of the following laboratory values?

- (A) Platelet count.
- (B) Clotting time.
- (C) Bleeding time.
- (D) Prothrombin time.

62. The LPN/LVN is reinforcing teaching with a client who is scheduled for a paracentesis. Which of the following statements by the client indicates that teaching has been successful?

- (A) "I will be in surgery for less than an hour."
- (B) "I must not void prior to the procedure."
- (C) "Two to 3 liters of fluid will be removed."
- (D) "I will lie on my back and breathe slowly."

63. The LPN/LVN is performing chest physiotherapy on a client with chronic airflow limitations (CAL). Which of the following actions should the nurse take first?

- (A) Perform chest physiotherapy prior to meals.
- (B) Auscultate breath sounds before the procedure.
- (C) Administer bronchodilators after the procedure.
- (D) Percuss each lobe prior to asking client to cough.

64. In which of the following situations would it be most appropriate for the LPN/LVN to wear a gown and gloves?

- (A) Administering oral medications to client with human immunodeficiency virus disease.
- (B) Assisting in the care of a motor vehicle accident victim who continues to bleed.
- (C) Bathing a client with an abdominal wound infection.
- (D) Changing the linen of a client with sickle-cell anemia.

65. A client is receiving 1,000 mL of 5% dextrose in half normal saline solution IV to infuse over 8 hours. The IV administration set tubing delivers 15 drops per milliliter. The LPN/LVN should expect the flow rate to be how many drops per minute?

- (A) 15.
- (B) 31.
- (C) 45.
- (D) 60.

66. A client is admitted to the hospital reporting seizures and a high fever. A positron emission tomography (PET) brain scan is ordered. Before the PET brain scan, the client asks the LPN/LVN what position is necessary for the test. Which of the following statements by the LPN/LVN is most accurate?

- (A) "You will be in a side-lying position, with the foot of the bed elevated."
- (B) "You will be in a semi-upright sitting position, with your knees flexed."
- (C) "You will be lying on your back with a small pillow under your head."
- (D) "You will be flat on your back, with your feet higher than your head."

67. A client with a diagnosis of delirium is admitted to the hospital. Blood samples are sent to the laboratory to help determine the underlying cause. Laboratory test results include sodium 156 mEq/L (156 mmol/L), chloride 100 mEq/L (100 mmol/L), potassium 4 mEq/L (4 mmol/L), bicarbonate 21 mEq/L (21 mmol/L), blood urea nitrogen (BUN) 86 mg/dL (30.7 mmol/L), glucose 100 mg/dL (5.5 mmol/L). Based on these laboratory results, the LPN/LVN would expect to see which of the following nursing diagnoses in the client's care plan?

- (A) Alteration in patterns of urinary elimination.
- (B) Fluid volume deficit.
- (C) Nutritional deficit: less than body requirements.
- (D) Self-care deficit: feeding.

68. A client is to receive 3,000 mL of normal saline solution IV to infuse over 24 hours. The IV administration set delivers 15 drops per milliliter. The LPN/LVN would expect the flow rate to be how many drops of fluid per minute?

- (A) 21.
- (B) 28.
- (C) 31.
- (D) 42.

69. The LPN/LVN is caring for a client diagnosed with asthma. The primary health care provider prescribes neostigmine IM. Which of the following actions by the LPN/LVN is most appropriate?

- (A) Administer medication, as prescribed.
- (B) Obtain the client's blood pressure and pulse.
- (C) Ask pharmacist if medication can be given orally.
- (D) Notify the primary health care provider.

70. The LPN/LVN is caring for a client with a history of Addison's disease who has received steroid therapy for several years. The LPN/LVN would expect the client to exhibit which of the following changes in appearance?

- (A) Buffalo hump, girdle-obesity, gaunt facial appearance.
- (B) Skin tanning, mucous membrane discoloration, weight loss.
- (C) Emaciation, nervousness, breast engorgement, hirsutism.
- (D) Truncal obesity, purple striations on the skin, moon face.

71. The LPN/LVN is caring for a client with a history of pancreatic cancer who appears jaundiced. The LPN/LVN should give the highest priority to which of the following needs?



- (A) Nutrition.
- (B) Self-image.
- (C) Skin integrity.
- (D) Urinary elimination.

72. An pediatric is seen in a clinic for treatment of attention-deficit/hyperactivity disorder (ADHD). Medication has been prescribed for the client along with family counseling. The LPN/LVN reinforces the teaching plan about the medication and discusses parenting strategies with the parents. Which of the following statements by the parents indicates that further teaching is necessary?

- (A) "We will give the medication at night so it doesn't decrease appetite."
- (B) "We will provide a regular routine for sleeping, eating, working, and playing."
- (C) "We will establish firm but reasonable limits on behavior."
- (D) "We will reduce distractions and external stimuli to help concentration."

73. The client diagnosed with anorexia nervosa is admitted to the hospital. Which of the following statements by the client requires immediate follow-up by the LPN/LVN?

- (A) "My gums bled this morning."
- (B) "I'm getting fatter every day."
- (C) "Nobody likes me, I'm so ugly."
- (D) "I feel dizzy and weak today."

74. A client is admitted to the hospital for treatment of Pneumocystis jiroveci pneumonia and Kaposi's sarcoma. The client informs the LPN/LVN about a personal decision to become an organ donor.

Which of the following responses by the LPN/LVN is best?

- (A) "What does your family think about your decision?"
- (B) "You will help many people by donating your organs."
- (C) "Would you like to speak to an organ donor coordinator?"
- (D) "Your illness prevents you from becoming an organ donor."

75. The LPN/LVN is caring for a client 2 days after a pancreatectomy for cancer of the pancreas. The LPN/LVN observes minimal drainage from the nasogastric (NG) tube. It is most important for the LPN/LVN to take which of the following actions?

- (A) Notify primary health care provider.
- (B) Monitor vital signs every 15 minutes.
- (C) Check the NG tube for kinking.
- (D) Replace the NG tube immediately.

76. The LPN/LVN is planning to administer furosemide 20 mg PO to a client diagnosed with chronic kidney disease. The client asks the LPN/LVN the reason for receiving this medication. Which of the following responses by the LPN/LVN is best?

- (A) "To increase the blood flow to your kidney."
- (B) "To decrease your circulating blood volume."
- (C) "To increase excretion of sodium and water."
- (D) "To decrease the workload on your heart."

77. The LPN/LVN is reinforcing discharge teaching for a client with Parkinson's disease. To maintain safety, the LPN/LVN should make which of the following suggestions to the family?

- (A) Install a raised toilet seat.
- (B) Obtain a hospital bed.
- (C) Instruct client to hold arms dependently during ambulation.
- (D) Participate in an exercise program during the late afternoon.

78. The LPN/LVN is reinforcing discharge teaching for a client with chronic pancreatitis. Which of the following statements by the client indicates that further teaching is necessary?

- (A) "I do not have to restrict physical activity."
- (B) "I should take pancrelipase before meals."
- (C) "I will eat three large meals every day."
- (D) "I need to avoid alcoholic beverages."

79. Following a laparoscopic cholecystectomy, the client reports abdominal pain and bloating. Which of the following responses by the LPN/LVN is best?

- (A) "Increase intake of fresh fruits and vegetables."
- (B) "I'll give you the prescribed pain medication."
- (C) "Why don't you take a walk down the hallway?"
- (D) "You may need an indwelling urinary catheter."

80. The nursing team consists of an RN, an unlicensed assistive personnel (UAP), and an LPN/LVN. The LPN/LVN would expect to be assigned to which of the following clients?

- (A) A client scheduled for MRI of the brain.
- (B) An unconscious client who requires a bed bath.
- (C) A client in balanced suspension traction.
- (D) A client with diabetes who needs help bathing.

81. The primary health care provider prescribes 1 L dextrose 5% in half normal saline solution IV to infuse over 8 hours. The drip factor stated on the IV administration set tubing is 15 gtt/mL. How many milliliters should the LPN/LVN expect to be infused every hour?

\_\_\_\_\_ mL

82. A client underwent vagotomy with antrectomy for treatment of a duodenal ulcer. Postoperatively, the client develops dumping syndrome. Which of the following statements by the client indicates to the LPN/LVN that further dietary teaching is necessary?

- (A) "I should eat bread with each meal."
- (B) "I should eat smaller meals more frequently."
- (C) "I should lie down right after eating."
- (D) "I should avoid drinking fluids with my meals."

83. The LPN/LVN reinforces discharge teaching with a client with emphysema. Which of the following statements by the client

indicates that teaching was successful?

- (A) "Cold weather should help my breathing problems."
- (B) "I'll eat three balanced meals daily but limit my fluid intake."
- (C) "I'll limit outside activity when pollution levels are high."
- (D) "Intensive exercise should help me regain strength."

84. A client has been taking aluminum hydroxide daily for 3 weeks. The LPN/LVN should be alert for which of the following side effects?

- (A) Nausea.
- (B) Hypercalcemia.
- (C) Constipation.
- (D) Anorexia.

85. The LPN/LVN is hearing a client call for help. The LPN/LVN enters the room and finds a client in bilateral wrist restraints with a cool, pale right hand and no palpable radial pulse. Which of the following would be the most appropriate action for the LPN/LVN to take first?

- (A) Leave to find the client's nurse.
- (B) Massage the client's wrist and hand.
- (C) Remove the right wrist restraint.
- (D) Reposition the client to reduce pressure.

86. The LPN/LVN is reinforcing discharge teaching for a client with a new colostomy. The LPN/LVN knows teaching was successful when the client chooses which of the following menu options?

- (A) Sausage, sauerkraut, baked potato, and fresh fruit.
- (B) Cheese omelet with bran muffin and fresh pineapple.
- (C) Pork chop, mashed potatoes, turnips, and salad.
- (D) Baked chicken, boiled potato, cooked carrots, and yogurt.

87. A client is admitted to the unit with suspected acute kidney injury. The LPN/LVN would be most concerned if the client made which of the following statements?

- (A) "My urine often appears pink-tinged."
- (B) "It is hard for me to start the flow of urine."
- (C) "It is quite painful for me to urinate."
- (D) "I urinate in the morning and again before dinner."

88. The LPN/LVN is implementing the protocol for teaching a new mother how to breastfeed her newborn. The LPN/LVN knows that teaching has been successful if the client makes which of the following statements?

- (A) "My baby's weight should equal the birthweight in 5 to 7 days."
- (B) "My baby should have at least 6 to 8 wet diapers per day."
- (C) "My baby will sleep at least 6 hours between feedings."
- (D) "My baby will feed for about 10 minutes per feeding."

89. A client is admitted to the telemetry unit for evaluation of reported chest pain. Eight hours after admission, the client's cardiac monitor shows ventricular fibrillation. The primary health care provider

defibrillates the client. The LPN/LVN understands that the purpose of defibrillation is to do which of the following?

- (A) Increase cardiac contractility, preload, and cardiac output.
- (B) Depolarize cells allowing SA node to recapture pacing node
- (C) Reduce the degree of cardiac ischemia and acidosis.
- (D) Provide electrical energy for depleted myocardial cells.

90. The LPN/LVN is caring for a client who suddenly reports chest pain. The LPN/LVN knows that which of the following symptoms would be most characteristic of an acute myocardial infarction (MI)?

- (A) Intermittent, localized epigastric pain.
- (B) Sharp, localized, unilateral chest pain.
- (C) Severe substernal pain radiating down the left arm.
- (D) Sharp, burning chest pain moving from place to place.

91. The primary health care provider prescribes packing for a nonhealing open surgical wound. Which of the following is the first action by the LPN/LVN?

- (A) Identify wound size, shape, and depth.
- (B) Observe for wound drainage or discharge.
- (C) Plan to set up for clean technique.
- (D) Select the proper dressing material.

92. A client returns to the clinic 2 weeks after hospital discharge. The client is taking warfarin sodium 2 mg PO daily. Which of the

following statements by the client to the LPN/LVN indicates that further teaching is necessary?

- (A) "I take an antihistamine before bedtime."
- (B) "I take aspirin whenever I have a headache."
- (C) "I put on sunscreen whenever I go outside."
- (D) "I take an antacid if my stomach gets upset."

93. To enhance the percutaneous absorption of nitroglycerin ointment, it would be most important for the LPN/LVN to select a site that is which of the following?

- (A) Muscular.
- (B) Near the heart.
- (C) Non-hairy.
- (D) Bony prominence.

94. When assisting the RN in planning care for a postoperative client, which of the following should be the first choice of the LPN/LVN to reduce the client's risk for pooled airway secretions and decreased chest wall expansion?

- (A) Chest percussion.
- (B) Incentive spirometry.
- (C) Position changes.
- (D) Postural drainage.

95. Which of the following actions by the LPN/LVN would be most helpful in preventing injury to elderly clients in a health care



facility?

- (A) Closely monitor the temperature of hot oral fluids.
- (B) Keep unnecessary furniture out of the way.
- (C) Maintain the safe function of all electrical equipment.
- (D) Use safety protection caps on all medications.

96. Which of the following statements by a client during a group therapy session requires immediate follow-up by the LPN/LVN?

- (A) "I know I'm a chronically compulsive liar, but I can't help it."
- (B) "I don't ever want to go home; I feel safer here."
- (C) "I don't really care if I ever see my girlfriend again."
- (D) "I'll make sure that doctor is sorry for what he said."

97. A client newly diagnosed with major neurocognitive disorder (NCD) due to Alzheimer's disease is admitted to the unit. Which of the following actions by the LPN/LVN is best?

- (A) Place the client in a semi-private room away from the nurses' station.
- (B) Ask family members to wait in the waiting room during the admission process.
- (C) Assign a different nurse daily to care for the client.
- (D) Ask the client to state the current date.

98. A female client visits the clinic reporting right calf tenderness and pain. It would be most important for the LPN/LVN to ask which of the following questions?

- (A) “Do you exercise excessively?”
- (B) “Have you had any recent fractures?”
- (C) “What type of birth control do you use?”
- (D) “Are you under a lot of stress?”

99. Which of the following should be the LPN/LVN’s first priority in providing care for a client who has end-stage ovarian cancer and has been weakened by chemotherapy?

- (A) Collect data to see if client has pain.
- (B) Determine if the client is hungry or thirsty.
- (C) Explore client’s feelings about dying.
- (D) Observe the client’s self-care abilities.

100. The LPN/LVN in the postpartum unit is caring for a client who delivered her first child the previous day. The LPN/LVN notes multiple varicosities on the client’s lower extremities. Which of the following actions should the LPN/LVN perform?

- (A) Teach the client to rest in bed when the baby sleeps.
- (B) Encourage early and frequent ambulation.
- (C) Apply warm soaks for 20 minutes every 4 hours.
- (D) Perform passive range-of-motion exercises 3 times daily.

101. The LPN/LVN is caring for a client who sustained a left femur fracture in a bicycle accident. A cast is applied. The nurse knows that which of the following exercises would be most beneficial for this client?

- (A) Passive exercise of the affected limb.
- (B) Quadriceps setting of the affected limb.
- (C) Active range-of-motion exercises of unaffected limb.
- (D) Passive exercise of the upper extremities.

102. In preparation for a dressing change, the LPN/LVN puts on sterile gloves. Where should the LPN/LVN initially grip the first sterile glove?



103. A client is being discharged from the hospital following a right total hip arthroplasty. The LPN/LVN reinforces discharge teaching. Which of the following statements by the client indicates that teaching was successful?

- (A) "I can bend over to pick up something on the floor."
- (B) "I should not cross my ankles when sitting in a chair."
- (C) "I need to lie on my stomach when sleeping in bed."
- (D) "I should spread my knees apart to put on my shoes."

104. The LPN/LVN is caring for a client with continuous bladder irrigation. At 7 A.M., the LPN/LVN notes 4,200 mL of normal saline solution left in the irrigation bags. During the next shift (7 A.M. to 3 P.M.), the LPN/LVN hangs another 3,000 mL and empties a total of 5,625 mL from the urine drainage bag. At 3 P.M., there are 2,300 mL of irrigant left hanging. What is the actual urine output for the client from 7 A.M. to 3 P.M.?

\_\_\_\_\_ mL

105. The LPN/LVN is observing activities on a medical/surgical unit. The LPN/LVN should intervene if which of the following is observed?

- (A) A client's family member disposes of the client's used tissue in the bedside container before opening the roommate's milk carton.
- (B) An UAP removes gloves and washes hands for 15 seconds after emptying an indwelling urinary catheter.
- (C) An LPN/LVN puts on a gown, gloves, mask, and goggles prior to inserting a nasogastric tube.
- (D) A visitor talks with a client diagnosed with methicillin-resistant *Staphylococcus aureus* (MRSA) wound infection while eating lunch.

106. A client with a history of type 1 diabetes mellitus is admitted to the unit reporting nausea, vomiting, and abdominal pain. The client reduced the insulin dose four days ago when influenza symptoms prevented eating. The LPN/LVN observes poor skin turgor, dry mucous membranes, and fruity breath odor. The LPN/LVN should be alert for which of the following problems?

- (A) Rebound hypoglycemia.
- (B) Viral gastrointestinal illness.
- (C) Diabetic ketoacidosis.
- (D) Hyperglycemic hyperosmolar nonketotic coma.

107. The LPN/LVN is caring for a group of clients. The nurse knows that it is most important for which of the following clients to receive scheduled medications on time?

- (A) A client diagnosed with myasthenia gravis receiving pyridostigmine bromide.
- (B) A client diagnosed with bipolar disorder receiving lithium carbonate.
- (C) A client diagnosed with tuberculosis receiving isonicotinic acid hydrazide.
- (D) A client diagnosed with Parkinson's disease receiving levodopa.

108. An school-age client is admitted to the hospital for evaluation for a kidney transplant. The LPN/LVN learns that the client received hemodialysis for 3 years due to stage 5 kidney disease. The LPN/LVN knows that the illness can interfere with this client's achievement of which of the following?

- (A) Intimacy.
- (B) Trust.
- (C) Industry.
- (D) Identity.

109. The LPN/LVN notes that a client has an unsteady gait. The LPN/LVN should do which of the following? Select all that apply.

- (A) Apply a chest or vest restraint at night.
- (B) Help the client put on nonskid shoes for walking.
- (C) Keep the call light within the client's reach.
- (D) Lower the bed and raise all 4 side rails.
- (E) Provide adequate lighting in room and bathroom.
- (F) Remove obstacles and room clutter.

110. Haloperidol 5 mg PO tid is prescribed for a client with schizophrenia. Two days later, the client reports "tight jaws and a stiff neck." The LPN/LVN should recognize that these complaints are which of the following?

- (A) Common side effects of therapy that will diminish over time.
- (B) Early symptoms of extrapyramidal reactions to the medication.
- (C) Psychosomatic symptoms resulting from a delusional system.
- (D) Permanent side effects associated with haloperidol therapy.

111. A client is receiving a continuous gastric tube feeding at 100 mL per hour. The LPN/LVN checks for gastric residual volume and finds 90 mL in the client's stomach. Which of the following actions should the LPN/LVN take?

- (A) Discard the gastric residual volume and continue the tube feeding.
- (B) Discard the gastric residual volume and stop the tube feeding.
- (C) Return the gastric residual volume and continue the tube feeding.
- (D) Return the gastric residual volume and stop the tube feeding.

112. The LPN/LVN is opening several sterile gauze dressings on the client's over-the-bed table. The LPN/LVN knows that the sterile dressings will be contaminated if LPN/LVN does which of the following?

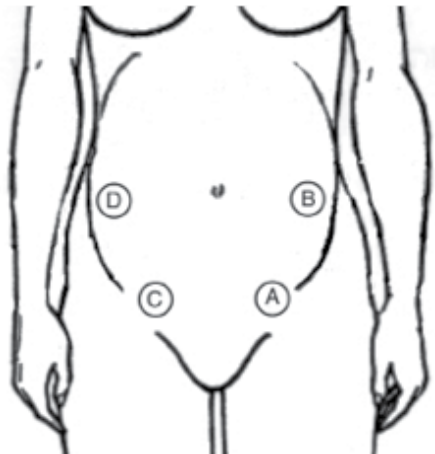
- (A) Does not allow the dressings prolonged exposure to the air.
- (B) Keeps sterile dressings inside border of the sterile packaging.
- (C) Positions top of the over-the-bed table at or above waist level.
- (D) Pours sterile saline onto the opened sterile dressing on table.

113. A client has adamantly refused hygiene measures over the past 3 days. Eventually the LPN/LVN was able to collaborate with the client to develop the hygiene goal: "self-administration of a complete bath daily while in the hospital." To evaluate if this goal is achieved, the LPN/LVN should do which of the following?



- (A) Ask the client whether self-bathing was accomplished.
- (B) Bathe the client to be sure the hygiene goal is met.
- (C) Observe the client performing portions of the daily bath.
- (D) Remind the client to bathe and provide the needed supplies.

114. The LPN/LVN is caring for a client in labor. The primary health care provider palpates a firm, round form in the uterine fundus, small parts on the client's right side, and a long, smooth, curved section on the left side. Based on these findings, where should the LPN/LVN anticipate auscultating the fetal heart tones?



- (A) A
- (B) B
- (C) C
- (D) D

115. When completing data collection of an immobilized client, the LPN/LVN knows that edema is commonly observed in which of the following locations?

- (A) Abdomen.
- (B) Feet and ankles.
- (C) Fingers and wrists.
- (D) Sacrum.

116. A client is preparing to take her 1-day-old infant home from the hospital. The LPN/LVN discusses the test for phenylketonuria (PKU) with the client. The LPN/LVN's reinforcement of teaching should be based on an understanding that the test is most reliable in which of the following circumstances?

- (A) After source of protein has been ingested.
- (B) After the meconium has been excreted.
- (C) After the danger of hyperbilirubinemia has passed.
- (D) After the effects of delivery have subsided.

117. The LPN/LVN is caring for an Rh-negative client who has delivered an Rh-positive child. The client states, "The doctor told me about RhoGAM, but I'm still a little confused." Which of the following responses by the LPN/LVN is most appropriate?

- (A) "RhoGAM is given to your child to prevent the development of antibodies."
- (B) "RhoGAM is given to your child to supply the necessary antibodies."
- (C) "RhoGAM is given to you to prevent the formation of antibodies."
- (D) "RhoGAM is given to you to encourage the production of antibodies."

118. A client is hospitalized with a diagnosis of bipolar disorder. While in the activities room on the psychiatric unit, the client flirts with other clients disrupting unit activities. Which of the following approaches would be most appropriate for the LPN/LVN to take at this time?

- (A) Set limits on the behavior and remind the client of the rules.
- (B) Distract the client and escort the client back to the room.
- (C) Instruct the other clients to ignore this client's behavior.
- (D) Inform client of negative behavior and return client to room.

119. A client is brought to the emergency department bleeding profusely from a stab wound in the left chest area. Vital signs include: blood pressure 80/50 mm Hg, pulse 110 beats/minute, and respiratory rate 28 breaths/minute. The LPN/LVN should expect which of the following potential problems?

- (A) Hypovolemic shock.
- (B) Cardiogenic shock.
- (C) Neurogenic shock.
- (D) Septic shock.

120. A client is admitted to the hospital for surgical repair of a detached retina in the right eye. In implementing the plan of care for this client postoperatively, the LPN/LVN should encourage the client to do which of the following?

- (A) Perform self-care activities.
- (B) Maintain patches over both eyes.
- (C) Limit movement of both eyes.
- (D) Refrain from excessive talking.

121. The LPN/LVN is caring for a client who receives a balanced complete formula through an enteral feeding tube. The LPN/LVN knows that the most common complication of an enteral tube feeding is which of the following?

- (A) Edema.
- (B) Diarrhea.
- (C) Hypokalemia.
- (D) Vomiting.

122. An infant is brought to the hospital for treatment of pyloric stenosis. The following nursing diagnosis is on the infant's care plan: "fluid volume deficit related to vomiting." The LPN/LVN would expect to see which of the following findings to support this diagnosis?

- (A) The infant eagerly accepts feedings.
- (B) The infant vomited once since admission.
- (C) The infant's skin is warm and moist.
- (D) The infant's anterior fontanel is depressed.

123. The LPN/LVN is caring for a preschool-age client diagnosed with a fractured pelvis caused by a motor vehicle accident. The LPN/LVN prepares the child for the application of a hip spica cast. It is most important for the LPN/LVN to take which of the following actions?

- (A) Obtain a doll for the client with a hip spica cast in place.
- (B) Tell the client that the cast will feel cold when applied.
- (C) Reassure the client that cast application is painless.
- (D) Introduce the client to another client who has a hip spica cast.

124. A client comes to the clinic because for suspected pregnancy. Tests confirm pregnancy. The client's last menstrual period began on September 8 and lasted for 6 days. The LPN/LVN calculates that her expected date of confinement (EDC) is which of the following?

- (A) May 15.
- (B) June 15.
- (C) June 21.
- (D) July 8.

125. An infant is brought to the pediatrician's office for a well-baby visit. During the examination, congenital subluxation of the left hip is suspected. The LPN/LVN would expect to see which of the following symptoms?

- (A) Lengthening of the limb on the affected side.
- (B) Deformities of the foot and ankle.
- (C) Asymmetry of the gluteal and thigh folds.
- (D) Plantarflexion of the foot.

126. After completing data collection, the LPN/LVN observes that a client is exhibiting early symptoms of a dystonic reaction related to the use of an antipsychotic medication. Which of the following actions by the LPN/LVN would be most appropriate?

- (A) Reality-test with the client and assure the client that physical symptoms are not real.
- (B) Teach the client about common side effects of antipsychotic medications.
- (C) Explain to the client that there is no treatment that will relieve these symptoms.
- (D) Notify the primary health care provider to obtain a prescription for IM diphenhydramine.

127. The LPN/LVN is preparing to perform oral care for an unconscious client. Which of the following actions should the LPN/LVN take first?

- (A) Assess for the presence of a gag reflex.
- (B) Place the client into Sims' position.
- (C) Separate teeth with a padded tongue blade.
- (D) Suction secretions from the oral cavity.

128. As a client nears death, the client's family member says, "I wish I could do something her." Which of the following responses by the LPN/LVN is most appropriate?

- (A) "It may be comforting if you talk to her calmly and clearly."
- (B) "She does not know that you are here, but you can sit here."
- (C) "Unfortunately, there is little that you can do at this point."
- (D) "Why don't you take a break? It is just a matter of time now."

129. The LPN/LVN is providing care to clients in a long-term care facility. Four meal choices are available to the clients. The LPN/LVN should ensure that a client on a low-cholesterol diet receives which of the following meals?

- (A) Egg custard and boiled liver.
- (B) Fried chicken and potatoes.
- (C) Hamburger and french fries.
- (D) Grilled flounder and green beans.

130. The LPN/LVN is removing a client's breakfast tray and notes that the client consumed 4 oz of pudding, 4 oz of gelatin, 6½ oz of tea, and 5 oz of apple juice. How many milliliters should the LPN/LVN record for the client's breakfast intake?

\_\_\_\_\_ mL

131. The LPN/LVN is caring for a client diagnosed with cholecystitis. The client says to the LPN/LVN, "I don't understand why my right shoulder hurts when the gallbladder is not by my shoulder!" Which of the following responses by the LPN/LVN is best?



- (A) "Sometimes small pieces of the gallstones break off and travel to other parts of the body."
- (B) "There is an invisible connection between the gallbladder and the right shoulder."
- (C) "The gallbladder is on the right side of the body and so is that shoulder."
- (D) "Your shoulder became tense because you were guarding against the gallbladder pain."

132. A client comes to the clinic at 32 weeks' gestation. A diagnosis of pregnancy-induced hypertension (PIH) is made. The LPN/LVN is reinforcing teaching performed by the RN. Which of the following statements by the client indicates that further teaching is required?

- (A) "Lying in bed on my left side is likely to increase my urinary output."
- (B) "If the bed rest works, I may lose a pound or two in the next few days."
- (C) "I should be sure to maintain a diet that has a good amount of protein."
- (D) "I will have to keep my room darkened and not watch much television."

133. The LPN/LVN is collecting data about a client's fluid balance. Which of the following findings most accurately indicates to the LPN/LVN that the client has retained fluid during the previous 24 hours?

- (A) Edema is found in both ankles.
- (B) Fluid intake is equal to fluid output.
- (C) Intake of fluid exceeds output by 200 mL.
- (D) Weight gain of 4 lb (1.8 kg) is noted.

134. The LPN/LVN is caring for a group of residents in a dependent-living facility. The LPN/LVN determines which of the following clients is most at risk to develop pneumonia?

- (A) A client female with left-sided hemiparesis after a stroke.
- (B) A client who has a history of hypertension and type 2 diabetes.
- (C) A client with a history of depression who walks one mile daily.
- (D) An client who smokes and has a history of lung cancer.

135. The LPN/LVN is caring for a client diagnosed with bipolar disorder. Which of the following behaviors by the client indicates that a manic episode is subsiding?

- (A) The client tells several jokes during a group meeting.
- (B) The client sits and talks with other clients at mealtimes.
- (C) The client begins to write a book about personal story.
- (D) The client initiates a unit effort to start a radio station.

136. A parent brings a child to the pediatrician for treatment of chronic otitis media. The parent asks the LPN/LVN how to prevent the child from getting ear infections. The LPN/LVN's response should be based on an understanding that the recurrence of otitis media can be decreased by which of the following?

- (A) Covering the child's ears while bathing.
- (B) Treating upper respiratory infections quickly.
- (C) Administering nose drops at bedtime.
- (D) Isolating the child from other children.

137. A client is calling the suicide prevention hotline to report a personal suicide plan. Which of the following questions should the LPN/LVN ask first?

- (A) "What happened to cause you to want to end your life?"
- (B) "Tell me the details of the plan you developed to kill yourself?"
- (C) "When did you start to feel as though you wanted to die?"
- (D) "Do you want me to prevent you from killing yourself?"

138. Prior to the client undergoing a scheduled intravenous pyelogram (IVP), it would be most important for the LPN/LVN to ask which of the following questions?

- (A) “Do you have any difficulty voiding?”
- (B) “Do you have any allergies to shellfish or iodine?”
- (C) “Do you have a history of constipation?”
- (D) “Do you have a history of frequent headaches?”

139. The LPN/LVN is assigned to a newly admitted elderly client in the hospital setting that reports having no living relatives and only friends of similar age. One of the LPN/LVN’s most immediate considerations for this client will be to help the RN implement which of the following?

- (A) A concept map.
- (B) A critical pathway.
- (C) A discharge plan.
- (D) A utilization group.

140. A client observes the LPN/LVN in the delivery room place drops in her newborn’s eyes. The client asks the LPN/LVN why this was done. Which of the following responses by the LPN/LVN is best?

- (A) “The drops constrict your baby’s pupils to prevent injury.”
- (B) “The drops will remove mucus from your baby’s eyes.”
- (C) “The drops will prevent infections that might cause blindness.”
- (D) “The drops will prevent neonatal conjunctivitis.”

141. The LPN/LVN is caring for a client admitted for a possible herniated intervertebral disk. The primary health care provider prescribed ibuprofen, propoxyphene hydrochloride, and cyclobenzaprine hydrochloride to be given as needed for pain. Several hours after admission, the client reports . Which of the following actions should the LPN/LVN take first?

- (A) Give the client ibuprofen to promptly manage the pain.
- (B) Ask the primary health care provider which drug to give first.
- (C) Gather more information from the client about the complaint.
- (D) Allow the client some time to rest to see if the pain subsides.

142. The LPN/LVN is completing a client's preoperative checklist prior to surgery. The nurse obtains the client's vital signs: temperature 97.4° F (36° C), radial pulse rate 84 beats/minute, respiratory rate 16 breaths/minute, and blood pressure 132/74 mm Hg. Which action should the LPN/LVN take first?

- (A) Notify the primary health care provider of client's vital signs.
- (B) Obtain orthostatic blood pressures lying and standing.
- (C) Lower the side rails and place the bed in its lowest position.
- (D) Record the data on the client's preoperative checklist.

143. The LPN/LVN is expecting to see which of the following physiological changes in a client experiencing an episode of acute pain?

- (A) Decreased blood pressure.
- (B) Decreased heart rate.
- (C) Decreased skin temperature.
- (D) Decreased respirations.

144. A client is transferred to a long-term care facility after a stroke. The client has right-sided paralysis and dysphagia. The LPN/LVN observes an unlicensed assistive personnel (UAP) preparing the client to eat lunch. Which of the following situations would require an intervention by the LPN/LVN?

- (A) The client remains in bed in the high Fowler's position.
- (B) The client's head and neck are positioned slightly forward.
- (C) The UAP places food in back of the mouth of unaffected side.
- (D) The UAP adds tap water to the pudding to help client swallow.

145. The LPN/LVN's is collecting data and a client's blood pressure is 146/92 mm Hg with labored respirations at a rate of 24 breaths/minute. Bloody drainage appears on the client's IV dressing. The client reports pain in the left hip, depression, and

hunger. The LPN/LVN identifies which of these as subjective data?  
Select all that apply.

- (A) Blood pressure.
- (B) Depression.
- (C) Hip pain.
- (D) Hunger.
- (E) IV drainage.
- (F) Respirations.

# Your Practice Test Scores

The test included in this book is designed to provide practice answering exam-style questions along with a review of nursing content. Your results on this test indicate where you are NOW. It is NOT designed to predict your ability to pass the NCLEX-PN® exam.

- If you scored 70% or better, you have a good understanding of essential nursing content and you are able to utilize the critical thinking skills required to answer exam-style questions.
- If you scored 60 to 69%, you have areas of essential nursing content that need further review, or you may need continued work to master the critical thinking skills needed to correctly answer exam-style questions.
- If you scored 59% or less, you need concentrated study of nursing content and continued practice utilizing the critical thinking skills required to be successful on the NCLEX-PN® exam.

If you are looking for additional preparation materials for the NCLEX-PN® exam, Kaplan's NCLEX-PN® Question Bank provides access to more than 1,000 practice questions. See the instructions in this book for how to sample the Question Bank for free. This resource is designed to develop both your knowledge of the nursing content as well as your critical thinking skills. Learn more at: [kaplannursing.com](http://kaplannursing.com) or call 800-527-8378 (outside the United States and Canada call 212-997-5883).





# Answer Key

## PRACTICE TEST

1. 3
2. 1
3. 4
4. 2
5. 1
6. 1
7. 3
8. 2
9. 2
10. 1
11. 3
12. 2
13. 4
14. 3
15. 2
16. 4
17. 2
18. 2
19. 2
20. 4
21. 3
22. 3

23. 2

24. 3

25. 2

26. 4

27. 1

28. 1

29. 4

30. 1

31. 3

32. 4

33. 3

34. 3

35. 4

36. 2

37. 1

38. 3

39. 3

40. 2

41. 3

42. 1

43. 2

44. 2

45. 2

46. 2

47. 3

48. 2

49. 1

50. 4

51. 4

52. 2

53. 4

54. 3

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56. 1

57. 2

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59. 4

60. 2

61. 2

62. 3

63. 2

64. 2

65. 2

66. 3

67. 2

68. 3

69. 4

70. 4

71. 1

72. 1

73. 4

74. 4

75. 3

76. 3

77. 1

78. 3

79. 3

80. 3

81. 125

82. 1

83. 3

84. 3

85. 3

86. 4

87. 4

88. 2

89. 2

90. 3

91. 1

92. 2

93. 3

94. 3

95. 2

96. 4

97. 4

98. 3

99. 1

00. 2

01. 2

02. See Answers and Explanations

03. 2

04. 725

05. 1

06. 3

07. 1

08. 3

09. 2, 3, 5, and 6

10. 2  
11. 4  
12. 4  
13. 3  
14. 1  
15. 4  
16. 1  
17. 3  
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19. 1  
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25. 3  
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34. 4  
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41. 3

42. 4

43. 3

44. 4

45. 2, 3, and 4

# Answers and Explanations

## PRACTICE TEST

### 1. The Answer is 3

The LPN/LVN is gathering data from a client who is receiving treatment for obsessive-compulsive disorder (OCD). Which of the following is the most important question the LPN/LVN should ask this client?

Reworded Question: What are the signs and symptoms of obsessive-compulsive disorder?

Strategy: “Most important” indicates there may be more than one correct response.

Needed Info: Obsessive-compulsive disorder is characterized by a history of obsessions and compulsions. Obsessions are recurrent and persistent thoughts, ideas, impulses, or images that are experienced as intrusive and senseless. The client may know that the thoughts are ridiculous or morbid but cannot stop, forget, or control them.

Compulsions are repetitive behaviors performed in a certain way to prevent discomfort and neutralize anxiety.

Category: Data Collection/Psychosocial Integrity

“Do you find yourself forgetting simple things?”—should be used to collect data for a client with suspected cognitive disorder

“Do you find it difficult to focus on a given task?”—collects data for disorders that disrupt the ability to concentrate, such as depression

“Do you have trouble controlling upsetting thoughts?”—CORRECT: one feature of obsessive-compulsive disorder is the client’s inability to control intrusive thoughts that repeat over and over

“Do you experience feelings of panic in a closed area?”—appropriate for client with suspected panic disorder related to closed spaces or claustrophobia

## 2. The Answer is 1

The LPN/LVN is caring for a client who states, “I just want to die.” The LPN/LVN should examine the client’s medical record for which of the following documents?

Reworded Question: What data does the LPN/LVN need to know?

Strategy: Determine the document that would address a client’s choice to die.

Needed Info: Advance directives: specific instructions by the client that are legally binding. Clients with advance directives must provide them in written form to the health care provider. Advance directives include the “do not resuscitate” instruction, living will, durable power of attorney/health care surrogate.

Category: Data Collection/Safe and Effective Care  
Environment/Coordinated Care



Advance directives—CORRECT: advance directives specify the client's wishes regarding health care decisions

Power of attorney—surrogate or proxy if the client is incompetent to make decisions

“Do not resuscitate” order—only one part of advance directives

Living will—only one part of advance directives

### 3. The Answer is 4

A newly admitted client with a history of seizures suddenly says to the LPN/LVN, “I hear drums.” Which of the following should the LPN/LVN do first?

Reworded Question: What does a sudden visual, olfactory, or auditory sensation often signal in a client with a history of seizures?

Strategy: Quickly review the most likely causes of the client's unusual perception.

Needed Info: Aura: brief sensory alteration often preceding seizure or migraine, likely for client with history of seizures. Petit mal seizures: usually occur in children, not associated with an aura. Grand mal seizures: involve loss of consciousness and convulsions.

Category: Evaluation/Physiological Integrity/Physiological Adaptation

Tell the client to ignore the drums—client is experiencing an auditory sensation that may signal the start of a seizure

Place the client in a darkened room away from the nurses' station—the client needs continued observation

Continue to question the client—many adult clients experience unusual sensory perceptions (an aura) before the onset of a seizure; this client has a history of seizures

Insert an oral airway in the client—CORRECT: an oral airway prevents the client from biting cheek or tongue during a seizure

#### 4. The Answer is 2

A client diagnosed with multiple myeloma is admitted to the unit after developing pneumonia. When the LPN/LVN enters the client's room wearing a mask, the client says in an irritated tone of voice, "Why are you wearing that mask?" Which of the following responses by the LPN/LVN is best?

Reworded Question: What is the most therapeutic response?

Strategy: Remember therapeutic communication.

Needed Info: Multiple myeloma: a neoplastic disease that infiltrates bone and bone marrow, causes anemia, renal lesions, and high globulin levels in blood; pneumonia is inflammatory process resulting in edema of lung tissue and extravasion of fluid into alveoli, causing hypoxia.

Category: Data Collection/Safe and Effective Care Environment/Safety and Infection Control

"The chest x-ray taken this morning indicates you have pneumonia."—does not help determine what client knows; primary health care provider is responsible for telling client the medical diagnosis

“What have you been told about the x-rays that were taken this morning?”—CORRECT: data collection; determines what client knows before responding; allows client to verbalize

“You have been placed on contact precautions due to your infection.”—certain types of pneumonia require droplet precautions

“I am trying to protect you from the germs in the hospital.”—certain types of pneumonia require droplet precautions

#### 5. The Answer is 1

A nursing team consists of an RN, an LPN/LVN, and a unlicensed assistive personnel (UAP). The LPN/LVN should be assigned to which of the following clients?

Reworded Question: Which client is an appropriate assignment for the LPN/LVN?

Strategy: Think about the skill level involved in each client’s care.

Needed Info: LPN/LVN: assists with implementation of care; performs procedures; differentiates normal from abnormal; cares for stable clients with predictable conditions; has knowledge of asepsis and dressing changes; administers medications (varies with educational background and state nurse practice act).

Category: Planning/Safe and Effective Care Environment/Coordinated Care

A client with a diabetic ulcer that requires a dressing change—  
CORRECT: stable client with an expected outcome

A client with cancer who is reporting bone pain—requires assessment; RN is the appropriate caregiver

A client with terminal cancer being transferred to hospice home care—requires nursing judgment; RN is the appropriate caregiver

A client with a fracture of the right leg who asks to use the urinal—standard unchanging procedure; would be assigned to the UAP

6. The Answer is 1

To determine the structural relationship of one hospital department with another, the LPN/LVN should consult which of the following?

Reworded Question: How does the LPN/LVN determine the relationship of one hospital department to another?

Strategy: Think about each answer.

Needed Info: The lateral lines on an organizational chart define the division and specializations of labor; the vertical lines explain the lines of authority and responsibility.

Category: Implementation/Safe and Effective Care/Coordinated Care

Organizational chart—CORRECT: delineates the overall organization structure, showing which departments exist and their relationships with one another both laterally and vertically

Job descriptions—focus is not on departmental relationships

Personnel policies—defines policies for the organization's employees

Procedures manual—defines standards of care for an institution

7. The Answer is 3

A client reports pain in the right lower extremity. The primary health care provider prescribes codeine 60 mg and aspirin grains X PO every 4 hours, as needed for pain. Each codeine tablet contains 15 mg of codeine. Each aspirin tablet contains 325 mg of aspirin. Which of the following should the LPN/LVN administer?

Reworded Question: What amount of medication should you give?

Strategy: Remember how to calculate dosages.

Needed Info: 60 mg = 1 grain.

Category: Implementation/Physiological Integrity/Pharmacological Therapies

2 codeine tablets and 4 aspirin tablets—inaccurate

4 codeine tablets and 3 aspirin tablets—inaccurate

4 codeine tablets and 2 aspirin tablets—CORRECT:  $60/x = 15/1$ ,  $x = 4$ ; 10 grains = 600 mg;  $325/1 = 600/x$ ,  $x = 1.8$  (round to 2)

3 codeine tablets and 3 aspirin tablets—inaccurate

8. The Answer is 2

The LPN/LVN is caring for a client receiving paroxetine. It is most important for the LPN/LVN to report which of the following to the physician?

Reworded Question: What is a potential drug interaction?

Strategy: “Most important” indicates priority.

Needed Info: Paroxetine (Paxil) is a selective serotonin reuptake inhibitor (SSRI) used to treat depression, panic disorder, obsessive-compulsive disorder; side effects include palpitations, bradycardia, nausea and vomiting, and decreased appetite.

Category: Evaluation/Physiological Integrity/Pharmacological Therapies

The client reports no appetite change—causes anorexia; monitor weight and nutritional intake; report continued weight loss

The client reports recently being started on digoxin—CORRECT: may decrease effectiveness of digoxin

The client reports applying sunscreen to go outdoors—appropriate action; prevents photosensitivity reactions

The client reports driving the car to work—driving is acceptable after determining client’s response to drug

#### 9. The Answer is 2

A client with a “do not resuscitate” order experiences a cardiac arrest. Which of the following is the first action the LPN/LVN should take?

Reworded Question: What actions are appropriate for a client with a do not reus order who has no heartbeat?

Strategy: Determine which actions meet DNR standards.

Needed Info: “Do not resuscitate” requires a written primary health care provider order in the medical record: no extraordinary care given in the

event of the client's death. Extraordinary care after cardiac or pulmonary cessation: cardiopulmonary resuscitation (CPR), medications, ventilators, defibrillation.

Category: Data Collection/Safe and Effective Care  
Environment/Coordinated Care

Administer lifesaving medications—"Do not resuscitate" means these medications are not given

Assess the client for signs of death—CORRECT: client has signs of death and requires further data collection to confirm death

Open the airway and give 2 breaths—CPR should not be initiated for clients with a "do not resuscitate" order

Summon the emergency code team—CPR should not be initiated for clients with a "do not resuscitate" order

10. The Answer is 1

An LPN/LVN is working in the newborn nursery. Which of the following client-care assignments should the LPN/LVN question?

Reworded Question: Which infant is outside the scope of practice for an LPN/LVN?

Strategy: Remember the ABCs (airway, breathing, circulation).

Needed Info: Need to meet client's needs. Physical stability of client is LPN/LVN's first concern. Most unstable client should be cared for by RN.

Category: Evaluation/Safe and Effective Care Environment/Coordinated Care

A 2-day-old client lying quietly alert with a heart rate of 185 beats/minute—CORRECT: client has tachycardia; normal resting rate is 120–160 beats/minute; requires further investigation

A 1-day-old client who is crying and has a bulging anterior fontanel—crying causes increased intracranial pressure, which normally causes fontanel to bulge

A 12-hour-old client whose respirations are 45 breaths/minute and irregular while being held—normal respiratory rate is 30–60 breaths/minute with apneic episodes

A 5-hour-old client whose hands and feet appear blue bilaterally while sleeping—acrocyanosis normally occurs for 2–6 hours after delivery due to poor peripheral circulation

11. The Answer is 3

The LPN/LVN is inserting a nasogastric (NG) tube. The LPN/LVN should use which of the following personal protective equipment during NG tube insertion?

Reworded Question: What is the correct standard precaution?

Strategy: Think about each answer choice. How does each piece of equipment protect the LPN/LVN?

Needed Info: Mask, eye protection, and face shield protect against mucous membrane exposure; used if activities are likely to generate



splashes or sprays. Gowns used if activities are likely to generate splashes or sprays.

Category: Planning/Safe and Effective Care Environment/Safety and Infection Control

Gloves, gown, goggles, and surgical cap—surgical caps offer protection to hair but aren't required

Sterile gloves, mask, and gown—sterile gloves are used to protect the client during sterile procedures

Gloves, gown, mask, and goggles—CORRECT: must use standard precautions on all clients; prevent skin and mucous membrane exposure when contact with blood or other body fluids is anticipated

Double gloves, goggles, mask, and surgical cap—surgical cap not required for standard precautions; unnecessary to double glove

12. The Answer is 2

The LPN/LVN is caring for clients in the outpatient clinic. Which of the following clients should the LPN/LVN see first?

Reworded Question: Who is the priority client?

Strategy: Think ABCs.

Needed Info: Need to meet client's needs. Physical stability is LPN/LVN's first concern. Client with most serious problem should be seen first.

Category: Planning/Safe and Effective Care Environment/Coordinated Care

A client with hepatitis A who states, “My arms and legs are itching.”—caused by accumulation of bile salts under the skin; treat with calamine lotion and antihistamines

A client with a cast on the right leg who states, “I have a funny feeling in my right leg.”—CORRECT: may indicate neurovascular compromise; requires immediate data collection

A client with osteomyelitis of the spine who states, “I am so nauseous that I can’t eat.”—requires follow-up, but not highest priority

A client with rheumatoid arthritis who states, “I am having trouble sleeping.”—requires data collection, but not a priority

### 13. The Answer is 4

Which of the following client assignments should an LPN/LVN question?

Reworded Question: Which client is an inappropriate assignment for an LPN/LVN?

Strategy: Think about the skill level involved in each client’s care.

Needed Info: Determine nursing care required to meet clients’ needs; take into account time required, complexity of activities, acuity of client, and infection control issues. Consider knowledge and abilities of staff members and decide which staff person is best able to provide care.

Category: Planning/Safe and Effective Care Environment/Coordinated Care

A client with a chest tube who is ambulating in the hallway—  
LPN/LVN can care for client

A client with a colostomy who requires colostomy irrigation  
assistance—LPN/LVN can care for client

A client with a right-sided stroke who requires assistance with  
bathing—LPN/LVN can care for client

A client who is refusing medication to treat cancer of the colon—  
CORRECT: requires the assessment skills of the RN

#### 14. The Answer is 3

The LPN/LVN is caring for a client with hepatitis B. The client is to be discharged the next day. The LPN/LVN would be most concerned if the client made which of the following statements?

Reworded Question: What is an incorrect statement about care with hepatitis B?

Strategy: “Most concerned” indicates you are looking for an incorrect statement.

Needed Info: Hepatitis A (HAV): high-risk groups include young children, institutions for custodial care, international travelers; fecal/oral transmission, poor sanitation; nursing considerations include prevention, improved sanitation, treat with gammaglobulin early postexposure, no preparation of food. Hepatitis B (HBV): high-risk groups include drug addicts, fetuses from infected mothers, homosexually active men, transfusions, health care workers; transmission by parenteral, sexual contact, blood/body fluids; nursing considerations include hepatitis vaccine, immune globulin (HBIG)

postexposure, chronic carriers (potential for chronicity 5–10%).  
Hepatitis C (HVC): high-risk groups include transfusions, international travelers; transmission by blood/body fluids; nursing considerations include great potential for chronicity. Delta hepatitis: high-risk groups same as for HBV; transmission coinfects with HBV, close personal contact.

Category: Evaluation/Safe and Effective Care Environment/Coordinated Care

“I must not share eating utensils with my family members.”—prevents transmission; handwashing before eating and after toileting very important

“I must use my own bath towel.”—prevents transmission; don’t share bed linens

“I’m glad that I can have intimate relations with my partner.”—CORRECT: avoid sexual contact until serologic indicators return to normal

“I must eat small, frequent meals.”—easier to tolerate than three standard meals; diet should be high in carbohydrates and calories

#### 15. The Answer is 2

The LPN/LVN is carrying out the plan for care of a client with anemia who reports weakness. Which of the following tasks could be assigned to the unlicensed assistive personnel (UAP)?

Reworded Question: What is an appropriate assignment for the UAP?

Strategy: Think about the skill level involved in each task.

Needed Info: Unlicensed assistive personnel (UAPs): assist with direct client care activities (bathing, transferring, ambulating, feeding, toileting, obtaining vital signs/height/weight/intake/output, housekeeping, transporting, stocking supplies); includes nurse aides, assistants, technicians, orderlies, nurse extenders; scope of nursing practice is limited.

Category: Evaluation/Safe and Effective Care Environment/Coordinated Care

Auscultate the client's breath sounds—requires data collection; could be performed by LPN/LVN and reported to RN

Set up the client's lunch tray—CORRECT: standard, unchanging procedure; decreases cardiac workload

Obtain client's dietary history—involves data collection; could be performed by LPN/LVN and reported to RN

Instruct client how to balance rest and activity—instruction required; could be performed by LPN/LVN following established plan of care

16. The Answer is 4

The LPN/LVN on the surgical floor is receiving hand-off report from the RN. Which of the following clients should the LPN/LVN see first?

Reworded Question: Which client is the least stable?

Strategy: Think ABCs.

Needed Info: Need to meet the client's needs. Physical stability is the LPN/LVN's first concern. Most unstable client should be seen first.

Category: Planning/Safe and Effective Care Environment/Coordinated Care

A client admitted 3 days ago with a gunshot wound; 1.5-cm area of dark drainage noted on the dressing—does not indicate acute bleeding; small amount of blood

A client who had a mastectomy 2 days ago; 23 mL of serosanguinous fluid noted in the wound drain—expected outcome

A client with a collapsed lung due to an accident; no drainage noted in the previous 8 hours—indicates resolution

A client who had an abdominal-perineal resection 3 days ago; client now reports chills—CORRECT: at risk for peritonitis; should be assessed by the RN for further symptoms of infection

#### 17. The Answer is 2

A client scheduled for a cardiac catheterization says to the LPN/LVN, “I know you were in here when I signed the consent form for the test. I thought I understood everything, but now I’m not so sure.” Which of the following responses by the LPN/LVN is best?

Reworded Question: Which response is most therapeutic?

Strategy: “Best” indicates that discrimination is required to answer the question.

Needed Info: Informed consent is obtained by the individual who will perform the test; explanation of the test and expected results, anticipated risks and discomforts, potential benefits, possible alternatives are discussed; consent can be withdrawn at any time.

Category: Evaluation/Safe and Effective Care Environment/Coordinated Care

“Why didn’t you listen more closely to the explanation?”—“why” questions are nontherapeutic; does not respond to the client’s feelings or concerns

“You sound as if you would like to ask more questions.”—  
CORRECT: directly responds to client’s statement by paraphrasing; implies encouragement of expression of client’s concern

“I’ll get you a pamphlet about cardiac catheterization.”—may be helpful, but first the nurse needs to clarify the client’s concerns through discussion

“That often happens during explanation of this procedure.”—does convey acceptance and lets the client know that the response is not abnormal; response is closed and does not allow client to express feelings or concerns

#### 18. The Answer is 2

A 1-day-old client diagnosed with intrauterine growth retardation has a high-pitched shrill cry and appears restless and irritable. The LPN/LVN also observes fist-sucking behavior. Based on this data, which of the following actions should the LPN/LVN take first?

Reworded Question: What do you do for a newborn client experiencing withdrawal?

Strategy: Determine the outcome of each answer.

Needed Info: Drug withdrawal may manifest from as early as 12 hours after birth up to 10 days after delivery. Symptoms: high-pitched cry, hyperreflexia, decreased sleep, diaphoresis, tachypnea, excessive mucus, vomiting, uncoordinated sucking. Nursing care: assess muscle tone, irritability, vital signs; administer phenobarbital as ordered; report symptoms of respiratory distress; reduce stimulation; provide adequate nutrition/fluids; monitor mother and newborn interactions.

Category: Implementation/Health Promotion and Maintenance

- Gently massage the client's back every 2 hours—may result in overstimulation of the client

- Tightly swaddle the client in a flexed position—CORRECT: promotes client's comfort and security

- Schedule feeding times every 3 to 4 hours—small, frequent feedings are preferable

- Encourage eye contact with the client during feedings—may result in overstimulation of client

19. The Answer is 2

The LPN/LVN visits a neighbor who is at 20 weeks' gestation. The neighbor reports nausea, headache, and blurred vision. The LPN/LVN notes that the neighbor has tremors and appears nervous and



diaphoretic. It would be most important for the LPN/LVN to ask which of the following questions?

Reworded Question: What is the priority data collection question?

Strategy: “Most important” indicates there may be more than one correct response.

Needed Info: Data collection: irritability, confusion, tremors, blurring of vision, coma, seizures, hypotension, tachycardia, skin cool and clammy, diaphoresis. Plan/implementation: liquids containing sugar if conscious, skim milk is ideal if tolerated; dextrose 50% IV if unconscious, glucagon; follow with additional carbohydrate in 15 minutes; determine and treat cause; client education; exercise regimen.

Category: Data Collection/Health Promotion and Maintenance

“Are you having menstrual-like cramps?”—symptoms of preterm labor

“When did you last eat or drink?”—CORRECT: classic symptoms of hypoglycemia; offer carbohydrate

“Have you been diagnosed with diabetes?”—need to determine if she is hypoglycemic

“Have you been lying on the couch?”—not relevant to hypoglycemia

20. The Answer is 4

The LPN/LVN notes that a client newly admitted to the pediatric unit is scratching the head almost constantly. It would be most important for

the LPN/LVN to take which of the following actions?

Reworded Question: What might head scratching indicate?

Strategy: Determine if data collection or implementation is appropriate.

Needed Info: Pediculosis (lice). Data collection: scalp—white eggs (nits) on hair shafts, itchy; body—macules and papules; pubis—red macules.

Category: Data Collection/Health Promotion and Maintenance

- Discuss basic hygiene with the parents—makes an assumption; must collect data first

- Instruct the child not to sleep with the dog—must first collect data to determine the problem

- Advise parents to contact an exterminator—not enough information to make this determination

- Observe the scalp for small white specks—CORRECT: nits (eggs) appear as small, white, oval flakes attached to hair shaft

21. The Answer is 3

The client diagnosed with major depressive disorder who was admitted to the psychiatric unit for treatment and observation a week ago suddenly appears cheerful and motivated. The LPN/LVN should be aware of which of the following?

Reworded Question: What is the significance of sudden mood changes in a depressed client?

Strategy: Know the signs of impending suicide.

Needed Info: Data collection for suicidal ideation, suicidal gestures, suicidal threats, and actual suicidal attempt. Clients who have developed a suicide plan are more serious about following through, and are at grave risk. Clients emerging from severe depression have more energy with which to formulate and carry out a suicide plan (for which they had no energy before treatment). The LPN/LVN should determine risk for suicide; suspect suicidal ideation in depressed client; ask the client if he is thinking about suicide; ask the client about the advantages and disadvantages of suicide to determine how client sees his situation; evaluate client's access to a method of suicide; and support the client's reason to live.

Category: Planning/Psychosocial Integrity

The client is likely sleeping well because of the medication—improved sleep patterns would not explain the client's sudden mood change

The client has made new friends and has a support group—support on the nursing unit would not explain the mood change

The client may have finalized a suicide plan—CORRECT: as depressed clients improve, their risk for suicide is greater because they are able to mobilize more energy to plan and execute suicide

The client is no longer depressed due to treatment—sudden cheerful and energetic mood does not indicate resolution of depression

The LPN/LVN is caring for clients in the GYN clinic. A client reports an off-white vaginal discharge with a curdlike appearance and vulvar itching. It would be most important for the LPN/LVN to ask which of the following questions?

Reworded Question: What is a predisposing factor to developing candidiasis?

Strategy: “Most important” indicates there may be more than one correct response.

Needed Info: *Candida albicans*. Symptoms: odorless, cheesy white discharge; itching, inflames vagina and perineum. Treatment: topical clotrimazole, nystatin.

Category: Data Collection/Health Promotion and Maintenance

“Do you routinely douche?”—not a factor in the development of candidiasis

“Are you sexually active?”—candidiasis not usually sexually transmitted; predisposing factors include glycosuria, pregnancy, and oral contraceptives

“What kind of birth control do you use?”—CORRECT: oral contraceptives predispose individuals to candidiasis

“Have you taken any cough medicine?”—no relationship between cough medicine and candidiasis

23. The Answer is 2

The primary health care provider orders application of an elastic wrap bandage for a client's left leg from toes to mid-thigh. The LPN/LVN should do which of the following?

Reworded Question: What should an LPN/LVN do for a bandaged extremity?

Strategy: Think of what is most important for a bandaged extremity.

Needed Info: Quality of circulation: determined by observing the color, motion, and sensitivity of an affected body part, particularly distal to the bandage.

Category: Data Collection/Safe and Effective Care Environment/Safety and Infection Control

- Increase friction between skin and bandage surfaces—would cause skin breakdown

- Leave a small distal portion of the extremity exposed—CORRECT: enables the LPN/LVN to determine the color, motion, and sensitivity of a distal body part

- Use multiple pins to secure the bandage—unnecessary

- Position the left leg in abduction—unnecessary

24. The Answer is 3

A client recovering from a laparoscopic laser cholecystectomy says to the LPN/LVN, "I hate the thought of eating a low-fat diet for the rest of my life." Which of the following responses by the LPN/LVN is most appropriate?

Reworded Question: Is a low-fat diet required indefinitely?

Strategy: “Most appropriate” indicates discrimination may be required to answer the question.

Needed Info: Laparoscopic laser cholecystectomy is removal of the gallbladder by laser through a laparoscope; monitor T-tube if present; observe for jaundice; monitor intake and output; monitor for pain and encourage early ambulation to rid the body of carbon dioxide.

Category: Implementation/Physiological Integrity/Physiological Adaptation

“I will ask the dietician to come speak with you.”—passing the responsibility; LPN/LVN should respond to the client

“What do you think is so bad about following a low-fat diet?”—does not respond directly to the client’s statement

“It may not be necessary for you to follow a low-fat diet for that long.”—CORRECT: fat restriction is usually lifted as the client tolerates fat; biliary ducts dilate sufficiently to accommodate bile volume that was held by the gallbladder

“At least you will be alive and not suffering that pain.”—nontherapeutic and judgmental

## 25. The Answer is 2

The LPN/LVN is caring for clients in a pediatric clinic. The mother of a 14-year-old male privately tells the LPN/LVN that she is worried about her son because she unexpectedly walked into his room and discovered him

masturbating. Which of the following responses by the LPN/LVN is most appropriate?

Reworded Question: What is the most therapeutic response?

Strategy: Remember therapeutic communication.

Needed Info: Male changes in puberty: increase in genital size; breast swelling; pubic, facial, axillary, and chest hair; deepening voice; production of functional sperm; nocturnal emissions. Psychosexual development: masturbation as expression of sexual tension; sexual fantasies; experimental sexual intercourse.

Category: Implementation/Health Promotion and Maintenance

“Tell your son he could go blind doing that.”—false information

“Masturbation is a normal part of sexual development.”—

CORRECT: true statement provides opportunity for sexual self-exploration

“He’s really too young to be masturbating.”—boys typically begin masturbating in early adolescence

“Why don’t you give him more privacy?”—judgmental; doesn’t take advantage of opportunity to teach

26. The Answer is 4

A client begins to breathe very rapidly. Which of the following actions by the LPN/LVN would be the most appropriate?

Reworded Question: What is the most appropriate action for a client experiencing tachypnea?

Strategy: “Most appropriate” indicates priority.

Needed Info: Tachypnea: rapid respirations, respirations greater than 20 breaths/minute. Changes in respiratory rate: gather additional data in order to provide complete information to the RN and primary health care provider.

Category: Data Collection/Safe and Effective Care  
Environment/Coordinated Care

Auscultate the client's apical pulse rate—initial data collection should be directed at respiratory data

Measure client's blood pressure and pulse—initial data collection should be directed at respiratory data

Notify the primary health care provider—the primary health care provider will need more data to respond to client's condition change

Obtain the client's oxygen saturation level—CORRECT: provides the LPN/LVN with data about the client's oxygen saturation

27. The Answer is 1

The LPN/LVN is planning morning care for a client hospitalized after a stroke resulting in left-sided paralysis and homonymous hemianopia. During morning care, the LPN/LVN should do which of the following?

Reworded Question: What should you do for morning care for this client?



Strategy: Think about the consequences of each answer choice.

Needed Info: Homonymous hemianopia: blindness in half of each visual field caused by damage to brain. Client cannot see past midline toward the side opposite the lesion without turning the head toward that side. Approach client from side that is not visually impaired. Reduce noise and complexity of decision making.

Category: Implementation/Physiological Integrity/Physiological Adaptation

- Provide morning care from the right side of the client—CORRECT: approach from side with intact vision

- Speak loudly and distinctly when talking with the client—no hearing loss

- Reduce the level of lighting in the client's room to prevent glare—  
increase light to assist with vision

- Provide client's care to reduce the client's energy expenditure—  
encourage independence

28. The Answer is 1

A primigravid client at 32 weeks' gestation comes to the clinic for her initial prenatal visit. The client reports periodic headaches and continually bumping into things. The LPN/LVN observes numerous bruises in various stages of healing around the client's breasts and abdomen. Vital signs are: BP 120/80, pulse 72 beats/minute, respirations 18 breaths/minute, and fetal heart tones 142 beats/minute. Which of the following responses by the LPN/LVN is best?

Reworded Question: What might bruising indicate?

Strategy: Determine if it is appropriate to collect data or implement.

Needed Info: Symptoms of domestic abuse: frequent visits to physician's office or emergency room for unexplained trauma; client being cued, silenced, or threatened by an accompanying family member; evidence of multiple old injuries, scars, healed fractures seen on x-ray; fearful, evasive, or inconsistent replies, or nonverbal behaviors such as flinching when approached or touched. Nursing care: provide privacy during initial interview to ensure perpetrator of violence does not remain with client; carefully document all injuries (with consent); determine safety of client by asking specific questions about weapons, substance abuse, extreme jealousy; develop with client a safety or escape plan; refer client to community resources.

Category: Data Collection/Health Promotion and Maintenance

“Are you battered by your partner?”—CORRECT: evidence of injury should be investigated; assess head, neck, chest, abdomen, breasts, upper extremities

“How do you feel about being pregnant?”—injuries take priority

“Tell me about your headaches.”—injuries take priority

“You may be more clumsy due to your size.”—assumption; need to collect data

29. The Answer is 4

The LPN/LVN is providing care for a client with chronic lung disease who is receiving oxygen through a nasal cannula. The LPN/LVN should expect

which of the following to occur?

Reworded Question: What physiological changes occur with chronic obstructive pulmonary disease (COPD) that affect oxygen usage?

Strategy: Note the guidelines for oxygen use for clients with COPD.

Needed Info: Clients with COPD retain carbon dioxide. Client's respiratory drive may be controlled by the level of oxygen present in the arterial blood. Administration of oxygen at high-liter flows can suppress the respiratory drive. Humidification effective only for flow rates above 5 L.

Category: Planning/Physiological Integrity/Physiological Adaptation

Arterial blood gases will be drawn q 2 hours—blood gases are not drawn that often unless the client is in acute distress

The client's oral intake will be restricted—fluids should be encouraged, not restricted

The client will be maintained on bed rest—client should rest as needed: maintaining the client on bed rest is unnecessary

The oxygen flow rate will be set at 3 L/minute or less—CORRECT: the respiratory drive for clients with COPD can be suppressed by high levels of oxygen

30. The Answer is 1

The LPN/LVN is caring for a pediatric client in a leg cast for treatment of a right ankle fracture. It is most important for the LPN/LVN to reinforce which of the following activities after discharge?

Reworded Question: What is the priority action for a client in a cast?

Strategy: Determine the outcome of each answer choice.

Needed Info: Immediate nursing care for plaster cast: don't cover cast until dry (48 hours), handle with palms not fingertips; don't rest on hard surfaces; elevate affected limb above heart on soft surface until dry; don't use head lamp; check for blueness or paleness, pain, numbness, tingling (if present, elevate area; if it persists, contact physician); client should remain inactive while cast dries. Intermediate nursing care: mobilize client, isometric exercises; check for break in cast or foul odor; tell client not to scratch skin under cast and not to put anything underneath cast; if fiberglass cast gets wet, dry with hair dryer on cool setting. After-cast nursing care: wash skin gently, apply baby powder/cornstarch/baby oil; have client gradually adjust to movement without support of cast; swelling is common, elevate limb and apply elastic bandage.

Category: Implementation/Physiological Integrity/Reduction of Risk Potential

The client performs isometric exercises of the right leg—CORRECT: contraction of muscle without moving joint; promotes venous return and circulation, prevents thrombi; quadriceps setting (push back knees into bed) and gluteal setting (push heels into bed)

The parent massages the client's right foot with moisturizer—will help prevent dryness of foot but does not address skin under cast

The parent cleans the leg cast with mild soap and water—unnecessary to clean cast

The parent elevates the right leg on several pillows—unnecessary

31. The Answer is 3

The LPN/LVN is caring for a client who had a thyroidectomy 12 hours ago for treatment of Graves' disease. The LPN/LVN would be most concerned if which of the following were observed?

Reworded Question: What is a complication after a thyroidectomy?

Strategy: "Most concerned" indicates a complication.

Needed Info: Nursing care for Graves' disease/hyperthyroidism: limit activities and provide frequent rest periods; advise light, cool clothing; avoid stimulants; use calm, unhurried approach; administer antithyroid medication, irradiation with I<sup>131</sup> PO. Post-thyroidectomy care: low or semi-Fowler's position; support head, neck, and shoulders to prevent flexion or hyperextension of suture line; tracheostomy set at bedside; observe for complications—laryngeal nerve injury, thyroid storm, hemorrhage, respiratory obstruction, tetany (decreased calcium from parathyroid involvement), check Chvostek's and Trousseau's signs.

Category: Data Collection/Physiological Integrity/Reduction of Risk Potential

The client's vital signs include: blood pressure 138/82 mm Hg, pulse 84 beats/minute, and respirations 16 breaths/minute—vital signs within normal limits

The client supports the head and neck to turn head to right—prevents stress on the incision

The client spontaneously flexes the wrist when the blood pressure is inflated during blood pressure measurement—CORRECT: carpal spasms indicate hypocalcemia

The client becomes drowsy and reports a sore throat—expected outcome after surgery

32. The Answer is 4

A client is admitted who reports severe pain in the right lower quadrant of the abdomen. Which of the following actions should the LPN/LVN take to assist the client with pain relief?

Reworded Question: What is an appropriate nonpharmacological method for pain relief?

Strategy: Determine the outcome of each answer choice.

Needed Info: Establish a 24-hour pain profile. Teach client about pain and its relief: explain quality and location of impending pain; slow, rhythmic breathing to promote relaxation; effects of analgesics and benefits of preventative approach; splinting techniques to reduce pain. Reduce anxiety and fears. Provide comfort measures: proper positioning; cool, well-ventilated, quiet room; back rub; allow for rest.

Category: Implementation/Physiological Integrity/Basic Care and Comfort

Encourage rhythmic, shallow breathing—slow, rhythmic deep breathing promotes relaxation

Massage the right lower quadrant of the abdomen—if appendicitis is suspected, massage or palpation should never be performed as these actions may cause the appendix to rupture

Apply a warm heating pad to the client's abdomen—if pain is caused by appendicitis, increased circulation from heat may cause appendix to rupture

Position the client for comfort using pillows—CORRECT:  
nonpharmacological methods of pain relief

33. The Answer is 3

Which of the following actions by the LPN/LVN would be considered negligence?

Reworded Question: What is incorrect behavior?

Strategy: Think about the consequences of each action.

Needed Info: Negligence is the unintentional action or failure to act of an LPN/LVN that a reasonable person would or would not perform in similar circumstances; can be an act of commission or omission.

Standards of care: the actions that other LPN/LVNs would take in the same or similar circumstances that provide for quality care. Nurse practice acts: state laws that determine the scope of the practice of nursing.

Category: Implementation/Safe and Effective Care Environment/Safety and Infection Control

Administering heparin subcutaneously into a client's abdomen without first aspirating for blood—correct procedure

Crushing furosemide and adding to a teaspoon of applesauce for an elderly client—correct procedure

Lowering the bed side rails after administering meperidine and hydroxyzine to a client preoperatively—CORRECT: bed side rails should be raised after administering preoperative medication

Placing a used syringe and needle in a sharps container in a client's room—correct procedure

#### 34. The Answer is 3

The LPN/LVN is teaching an elderly client with right-sided weakness how to use a cane. Which of the following behaviors by the client indicates that the teaching was effective?

Reworded Question: What is the appropriate technique used to ambulate with a cane?

Strategy: Determine the outcome of each answer choice.

Needed Info: Cane tip should have concentric rings (shock absorber for stability). Flex elbow 30 degrees and hold handle up; tip of cane should be 15 cm lateral to base of the fifth toe. Hold cane in hand opposite affected extremity; advance cane and affected leg; lean on cane when moving good leg. To manage stairs, step up on good leg, place the cane and affected leg on step; reverse when going down (“up with the good, down with the bad”); same sequence used with crutches.

Category: Evaluation/Physiological Integrity/Basic Care and Comfort



The client holds the cane with the right hand, moves the cane forward followed by the right leg, and then moves the left leg—should hold cane with the stronger (left) hand

The client holds the cane with the right hand, moves the cane forward followed by the left leg, and then moves the right leg—should hold cane with the stronger (left) hand

The client holds the cane with the left hand, moves the cane forward followed by the right leg, and then moves the left leg—**CORRECT:** the cane acts as a support and aids in weight-bearing for the weaker right leg

The client holds the cane with the left hand, moves the cane forward followed by the left leg, and then moves the right leg—cane needs to be a support and aid in weight-bearing for the weaker right leg

### 35. The Answer is 4

The LPN/LVN is caring for client whose vital signs have been within normal limits. Now vital signs include: tympanic temperature 103.6° F (39.7° C), pulse 82 beats/minute, regular and strong, respirations 14 breaths/minute, shallow and unlabored, and blood pressure 134/88 mm Hg. What should the LPN/LVN's next action be?

Reworded Question: What do you do first when you obtain a vital sign that represents a significant change in the client's status and conflicts with other data?

Strategy: Think about what other vital sign changes occur with a significant temperature elevation.

Needed Info: Vitals in normal range: pulse 82 beats/minute, respirations 14 breaths/minute, BP 134/88 (slightly elevated likely due to age).

Temperature significantly elevated: should result in a more rapid pulse rate and an increased respiratory rate due to increased cellular metabolism. Validation of the temperature reading with another thermometer is required to determine the accuracy of the initial temperature reading.

Category: Planning/Physiological Integrity/Physiological Adaptation

Notify primary health care provider immediately—the LPN/LVN should take responsibility for gathering additional data before calling the physician

Proceed with the client's care—a temperature elevation to 103.6° F (39.7° C) is abnormal

Record vital signs in medical record—the LPN/LVN should ensure the accuracy of reading before documenting them in a legal document

Retake the temperature with a different thermometer—CORRECT: a temperature of 103.6° F (39.7° C) is abnormal without a corresponding increase in pulse and respiratory rate, the thermometer may be defective

36. The Answer is 2

A client admitted to the hospital with right femur fracture is placed in balanced suspension traction with a Thomas splint and Pearson attachment. During the first 48 hours, the LPN/LVN should gather data related to which of the following complications?

Reworded Question: What complication of a fracture is seen in the first 48 hours?

Strategy: Be careful! They are asking for the complication that occurs during the first 48 hours. Later complications may be included.

Needed Info: Complications of fractures: (1) compartment syndrome (increased pressure externally [casts, dressings] or internally [bleeding, edema] resulting in compromised circulation); signs/symptoms (S/S): pallor, weak pulse, numbness, pain, (2) shock, (3) fat embolism, (4) deep vein thrombosis, (5) infection, avascular necrosis, (6) delayed union, nonunion, malunion of the bone.

Category: Data Collection/Physiological Integrity/Physiological Adaptation

Pulmonary embolism—obstruction of pulmonary system by thrombus from venous system or right side of heart; seen 2–3 days to several weeks after fracture

Fat embolism—CORRECT: fat moves into bloodstream from fracture; formed by alteration in lipids in blood; fat combines with platelets to form emboli; S/S: abnormal behavior due to cerebral anoxia (confusion, agitation, delirium, coma), abnormal arterial blood gases (ABGs) ( $pO_2$  below 60 mmHg), increased respiratory rate; chest pain, dyspnea, pallor, hypertension, petechiae on chest, upper arms, abdomen; treatment: high Fowler's position, high concentration  $O_2$ , ventilation with positive end expiratory pressure (PEEP) to decrease pulmonary edema, IV fluid to prevent shock, steroids

Avascular necrosis—(seen later than 48 hours) bone loses blood supply and dies; seen with chronic kidney disease or prolonged steroid use; treatment: bone graft, joint fusion, prosthetic replacement

Malunion—bone fragments heal in deformed position as a result of inadequate reduction and immobilization; treatment: surgical or manual manipulation to realign

37. The Answer is 1

The LPN/LVN is helping an unlicensed assistive personnel (UAP) provide a bed bath to a comatose client who is incontinent. The LPN/LVN should intervene if which of the following actions is noted?

Reworded Question: What is an incorrect action?

Strategy: “Should intervene” indicates that you are looking for something wrong.

Needed Info: Standard precautions used with all clients: primary strategy for preventing exposure to blood or body fluids. Gloves are worn when exposure to blood, body fluids, secretions, excretions, or contaminated articles is likely; remove and discard promptly after use, and perform hand hygiene, before touching items and environmental surfaces to reduce the risk for pathogen transmission.

Category: Evaluation/Safe and Effective Care Environment/Safety and Infection Control

The UAP answers the phone while wearing gloves—CORRECT: contaminated gloves should be removed and discarded, and then hand hygiene performed before answering the phone.

The UAP log-rolls the client to provide back care—appropriate action, maintains proper body alignment

The UAP places an incontinence pad under the client—appropriate for a client with incontinence

The UAP positions the client on the left side, with the head of bed elevated—appropriate position to prevent aspiration and protect the client's airway

### 38. The Answer is 3

A client is brought to the emergency department for treatment after being found on the floor by a family member. When comparing the legs, the LPN/LVN would most likely make which of the following observations?

Reworded Question: What is a symptom of a hip fracture?

Strategy: Think about each answer choice.

Needed Info: Symptoms of fracture: swelling, pallor, ecchymosis; loss of sensation to other body parts; deformity; pain, acute tenderness, or both; muscle spasms; loss of function, abnormal mobility; crepitus (grating sound on movement); shortening of affected limb; decreased or absent pulses distal to injury; affected extremity colder than contralateral part. Emergency nursing care: immobilize joint above and below fracture using splints before moving client; in open fracture, cover the wound with sterile dressings or cleanest material available, control

bleeding by direct pressure; check temperature, color, sensation, capillary refill time distal to fracture; in emergency department, manage pain.

Category: Data Collection/Physiological Integrity/Physiological Adaptation

The client's left leg is longer than the right leg and externally rotated—affected leg shortens due to contraction of muscles attached above and below fracture site

The client's left leg is shorter than the right leg and internally rotated—affected leg is usually externally rotated

The client's left leg is shorter than the right leg and adducted—  
CORRECT: affected leg shortens due to contraction of muscles attached above and below fracture site, fragments overlap by 1–2 inches (2.5 to 5 cm)

The client's left leg is longer than the right leg and is abducted—affected leg shortens and externally rotates

39. The Answer is 3

The LPN/LVN is caring for a client with a cast on the left leg. The LPN/LVN would be most concerned if which of the following is observed?

Reworded Question: What is a complication of a cast?

Strategy: “Most concerned” indicates a complication.

Needed Info: Immediate nursing care for plaster cast: Don't cover cast until dry (48 hours), handle with palms not fingertips; don't rest on hard

surfaces; elevate affected limb above heart on soft surface until dry; don't use heat lamp; check for blueness or paleness, pain, numbness, tingling (if present, elevate area; if it persists, contact primary health care provider); client should remain inactive while cast dries.

Intermediate nursing care: mobilize client, isometric exercises; check for break in cast or foul odor; tell client not to scratch skin under cast and not to put anything underneath cast; if fiberglass cast gets wet, dry with hair dryer on cool setting. After-cast nursing care: Wash skin gently; have client gradually adjust to movement without support of cast; swelling is common, elevate limb.

Category: Data Collection/Physiological Integrity/Physiological Adaptation

Capillary refill time is less than 3 seconds—capillary refill time is within normal limits

Client reports discomfort and itching—a casted extremity may itch or feel uncomfortable due to prolonged immobility

Client reports of tightness and pain—CORRECT: pain and tightness may develop if swelling occurs and the cast becomes too tight; if left untreated compartment syndrome may develop

Client's foot is elevated on a pillow—newly casted extremity may be slightly elevated to help relieve edema; it should remain in correct anatomical position and below heart level to allow sufficient arterial perfusion

40. The Answer is 2

The LPN/LVN is assisting with discharging a client from an inpatient alcohol treatment unit. Which of the following statements by the client's

wife indicates that the family is coping adaptively?

Reworded Question: What indicates that the client's family is coping with the client's alcoholism?

Strategy: Think about what each statement means.

Needed Info: Nursing care for alcohol use disorder: safety; monitor for withdrawal; reality orientation; increase self-esteem and coping skills; balanced diet; abstinence from alcohol; identify problems related to drinking in family relationships, work, etc.; help client to see/admit problem; confront denial with slow persistence; maintain relationship with client; establish control of problem drinking; provide support; Alcoholics Anonymous; disulfiram (Antabuse): drug used to maintain sobriety, based on behavioral therapy.

Category: Evaluation/Psychosocial Integrity

“My husband will do well as long as I keep him engaged in activities that he likes.”—wife is accepting responsibility; codependent behavior

“My focus is learning how to live my life.”—CORRECT: wife is working to change codependent patterns

“I am so glad that our problems are behind us.”—unrealistic; discharge is not the final step of treatment

“I’ll make sure that the children don’t give my husband any problems.”—wife is accepting responsibility; codependent behavior



An LPN/LVN is caring for clients in the mental health clinic. A client reporting insomnia and anorexia tearfully tells the LPN/LVN about a personal job loss after 15 years of employment with the company. Which of the following responses by the LPN/LVN is most appropriate?

Reworded Question: What is the most therapeutic response?

Strategy: Remember therapeutic communication.

Needed Info: Nursing considerations, explore client's understanding of the problem: focus on the present; emphasize client's strengths; avoid blaming; determine how client handled similar situations; provide support; mobilize client's coping strategies.

Category: Implementation/Psychosocial Integrity

“Did you receive a severance package?”—yes or no questions are not therapeutic

“Focus on your healthy, happy family.”—gives advice and dismisses the client's feelings

“Explain what happened with your job.”—CORRECT: validates the client's concern and further explores situation; encourages the client to verbalize feelings

“Job loss is very common these days..”—dismisses the client's concern

42. The Answer is 1

A client with a history of alcohol use disorder is transferred to the unit in an agitated state. The client is vomiting and diaphoretic, and states that

it has been 5 hours since the last drink. The LPN/LVN would expect to administer which of the following medications?

Reworded Question: What is the best medication to treat acute alcohol withdrawal?

Strategy: Think about the action of each drug.

Needed Info: Alcohol sedates the central nervous system (CNS); rebound during withdrawal. Early symptoms occur 4–6 hours after last drink.

Symptoms: tremors; easily startled; insomnia; anxiety; anorexia; alcoholic hallucinosis (48 hours after last drink). Nursing care: administer sedation as needed, usually benzodiazepines; monitor vital signs, particularly pulse; institute seizure precautions; provide a quiet, well-lit environment; orient client frequently; don't leave hallucinating, confused client alone; administer anticonvulsants as needed, thiamine IV or IM, and IV dextrose.

Category: Planning/Psychosocial Integrity

Chlordiazepoxide—CORRECT: antianxiety; used to treat symptoms of acute alcohol withdrawal; side effects (S/E): lethargy, hangover effect, agranulocytosis

Disulfiram—used as a deterrent to compulsive drinking; contraindicated within 12 hours of alcohol consumption

Methadone—opioid agonist; used to treat opioid withdrawal syndrome; S/E: respiratory depression, hypotension, dizziness, lightheadedness

Naloxone—opioid antagonist used to reverse opioid-induced respiratory depression; S/E: ventricular fibrillation, seizures, pulmonary edema

43. The Answer is 2

The LPN/LVN is caring for a client diagnosed with end-stage colon cancer. The spouse of the client says, “We have been married for so long. I am not sure how I can go on now.” What is the most appropriate response by the LPN/LVN?

Reworded Question: What is the most therapeutic response to the spouse of the person diagnosed with terminal colon cancer?

Strategy: Remember therapeutic communication.

Needed Info: The client in this interaction is the spouse of the client diagnosed with end-stage colon cancer; focus on the present; encourage verbalization of feelings; provide support.

Category: Implementation/Psychosocial Integrity

“It sounds like your children will be there to help during your time of grieving.”—dismisses client’s concern; keep focus on client

“I know this is difficult. Tell me more about what you are feeling now.”—CORRECT: acknowledges client’s feelings; allows client to express feelings

“Think about the pain and suffering your spouse has endured lately.”—gives advice; discourages verbalization

“I will call the hospice nurse to discuss to your spouse's condition with you.” —passes responsibility to the hospice nurse; instead the LPN/LVN should encourage the spouse to express feelings

44. The Answer is 2

The LPN/LVN is reinforcing teaching with an elderly client about how to use a standard aluminum walker. Which of the following behaviors by the client indicates that the reinforcement of teaching was effective?

Reworded Question: What is the correct technique when ambulating with a walker?

Strategy: Determine the outcome of each answer choice.

Needed Info: Elbows flexed at 20- to 30-degree angle when standing with hands on grips. Lift and move walker forward 8–10 inches (20–25 cm). With partial or non-weight-bearing, put weight on wrists and arms and step forward with affected leg, supporting self on arms, and follow with good leg. Nurse should stand behind client, hold onto gait belt at waist as needed for balance. Sit down by grasping armrest on affected side, shift weight to good leg and hand, lower self into chair. Client should wear sturdy shoes.

Category: Evaluation/Physiological Integrity/Basic Care and Comfort

The client slowly pushes the walker forward 12 inches (30 cm), then takes small steps forward while leaning on the walker—should not push the walker

The client lifts the walker, moves it forward 10 inches (25 cm), and then takes several small steps forward—CORRECT: the client should pick up the walker, and then place it down on all legs

The client supports weight on the walker while advancing it forward, then takes small steps while balancing on the walker—the client should not support weight on walker while trying to move it

The client slides the walker 18 inches (46 cm) forward, then takes small steps while holding onto the walker for balance—client should pick up the walker, not slide it forward

45. The Answer is 2

An LPN/LVN is providing care for a group of elderly clients in a long-term care facility. The LPN/LVN knows that the elderly are at greater risk of developing sensory deprivation for which of the following reasons?

Reworded Question: Why do the elderly have sensory deprivation?

Strategy: Think about each answer choice.

Needed Info: Plan/implementation: assist client with adjusting to lifestyle changes; allow client to verbalize concerns; prevent isolation; provide assistance as required.

Category: Implementation/Psychosocial Integrity

Increased sensitivity to the side effects of medications—many medications alter GI function but do not cause decreased vision, hearing, or taste

Decreased visual, auditory, and gustatory abilities—CORRECT: gradual loss of sight, hearing, and taste interferes with normal functioning

Isolation from their families and familiar surroundings—clients are in contact with other residents and staff who provide stimulation

Decreased musculoskeletal function and mobility—clients can be mobilized in wheelchairs, if necessary

46. The Answer is 2

The LPN/LVN would expect which of the following clients to be able to sign a consent form for nonemergent medical treatment?

Reworded Question: Which of these clients can give consent for own medical treatment?

Strategy: Think about the requirements for informed consent in nonemergent medical situations.

Needed Info: Clients requiring consent by an agent: under 18 years of age unless emancipated, declared legally incompetent, under the influence of drugs or alcohol, unable to understand or respond to information. In emergency situations: assumption that clients would want to be treated.

Category: Planning/Safe and Effective Care Environment/Coordinated Care

A school-age child with a right tibia and fibula fracture—this client requires the consent of the legal guardian in this nonemergent

situation

A client requiring surgery for acute appendicitis—CORRECT: this client can provide own informed consent

A client who is confused after a motor vehicle accident —informed consent would be required from designate health care agent in this nonemergent situation

A client who has been legally declared incompetent—consent is required from the designate health care agent in this nonemergent situation

#### 47. The Answer is 3

An LPN/LVN is assisting with the discharge of a client with a diagnosis of hepatitis of unknown etiology. The LPN/LVN knows that teaching has been successful if the client makes which of the following statements?

Reworded Question: What is a correct statement about hepatitis?

Strategy: Determine the outcome of each statement.

Needed Info: Hepatitis A (HAV): high-risk groups include young children, residents of institutions for custodial care, international travelers; transmission by fecal/oral route, poor sanitation; nursing considerations include prevention, improved sanitation, treat with gammaglobulin early postexposure, no preparation of food. Hepatitis B (HBV): high-risk groups include drug addicts, fetuses from infected mothers, homosexually active men, transfusions, health care workers; transmission by parenteral, sexual contact, blood/body fluids; nursing considerations include hepatitis vaccine, immune globulin (HBIG) postexposure, chronic carriers (potential for chronicity 5–10%).

Hepatitis C (HVC): high-risk groups include transfusions, international travelers; transmission by blood or body fluids. Delta hepatitis: high-risk groups same as for HBV; transmission coinfects with HBV, transmitted through close personal contact.

Category: Evaluation/Physiological Integrity/Reduction of Risk Potential

“I am so sad that I am not able to hold my baby.”—hepatitis not spread by casual contact

“I will eat my meal after my family finishes eating.”—client can eat with family; cannot share eating utensils

“I will make sure that my children don’t use my eating utensils—  
CORRECT: to hepatitis transmission, the client should not share eating utensils or drinking glasses, and should wash hands before eating and after using the toilet

“I’m glad that I don’t have to get help taking care of my children.”—need to alternate rest and activity to promote hepatic healing; mothers of young children will need help

48. The Answer is 2

The LPN/LVN checks the IV flow rate for a postoperative client. The client is to receive 3,000 mL of lactated Ringer’s lactate solution IV infused over 24 hours. The IV administration set has a drop factor of 10 drops per milliliter. The LPN/LVN would expect the client’s IV to infusing at how many drops per minute?

Reworded Question: What is the IV flow rate?



Strategy: Remember the formula to calculate IV flow rate: total volume × drop factor divided by the time in minutes.

Needed Info: Lactated Ringer's: electrolyte solution used to expand extracellular fluid volume, and reduce blood viscosity.

Category: Implementation/Physiological Integrity/Pharmacological Therapies

18—incorrect

21—CORRECT:  $(3,000 \times 10)$  divided by  $(24 \times 60) = 30,000$  divided by 1,440 = 20.8 = 21

35—incorrect

40—incorrect

49. The Answer is 1

A client diagnosed with emphysema becomes restless and confused. Which of the following actions should the LPN/LVN take next?

Reworded Question: What should the LPN/LVN do to raise the oxygen levels of a client with emphysema?

Strategy: Determine the outcome of each answer choice.

Needed Info: Emphysema: overinflation of alveoli resulting in destruction of alveoli walls; predisposing factors include smoking, chronic infections, environmental pollution. Teaching includes breathing exercises; stop smoking; avoid hot and cold air or allergens; instructions regarding medications; avoid crowds or close contact with

persons who have colds or influenza; adequate rest and nutrition; oral hygiene; influenza vaccines; observe sputum for indications of infection.

Category: Implementation/Physiological Integrity/Reduction of Risk Potential

Encourage pursed-lip breathing—CORRECT: purse-lipped breathing helps the client control the rate and depth of breathing

Measure the client's temperature—confusion is probably due to decreased oxygenation

Assess the client's potassium level—confusion is most likely caused by poor oxygenation, not electrolyte imbalance

Increase the client's oxygen flow rate to 5 L/minute—should receive low flow oxygen to prevent carbon dioxide narcosis

50. The Answer is 4

The LPN/LVN is caring for a client following cataract surgery on the right eye. The client reports severe eye pain in the right eye. Which of the following activities should the LPN/LVN do first?

Reworded Question: Is pain after cataract surgery normal?

Strategy: Remember what you know about cataract removal.

Needed Info: Cataract: change in the transparency of crystalline lens of eye. Causes: aging, trauma, congenital, systemic disease. S/S: blurred vision, decrease in color perception, photophobia. Treated by removal of lens under local anesthesia with sedation. Intraocular lens

implantation, eyeglasses, or contact lenses after surgery. Complications: glaucoma, infection, bleeding, retinal detachment.

Category: Planning/Physiological Integrity/Reduction of Risk Potential

Administer an analgesic to the client—mild discomfort treated with analgesics

Recheck the client's condition in 30 minutes—action should be taken immediately

Document finding in client's medical record—action should be taken immediately

Report the finding to the supervising RN—CORRECT: ruptured blood vessel or suture causing hemorrhage or increased intraocular pressure; notify primary health care provider for restlessness, increased pulse rate, drainage on dressing

51. The Answer is 4

The LPN/LVN is caring for a client 4 hours after intracranial surgery. Which of the following actions should the LPN/LVN take immediately?

Reworded Question: What is a priority after intracranial surgery?

Strategy: Determine the outcome of each answer choice.

Needed Info: Monitor vital signs hourly. Elevate head 30 to 45 degrees (as ordered) to promote venous return from brain, and prevent increased intracranial pressure (ICP). Avoid neck flexion and head rotation. Reduce environmental stimuli. Prevent the Valsalva maneuver by teaching the client to exhale when turning or moving in bed.

Administer stool softeners. Restrict fluids to 1,200–1,500 mL/day.

Administer medications: an osmotic diuretic, corticosteroid and anticonvulsant.

Category: Implementation/Physiological Integrity/Reduction of Risk Potential

Instruct the client to deep breathe, cough, and expectorate into a tissue—coughing should be avoided because it increases ICP

Position the client in a left lateral position with neck flexed—the head should be maintained in a neutral position to promote venous return and reduce risk for increased ICP

Perform passive range-of-motion exercises every two hours—position changes required during range-of-motion exercises can increase ICP

Use a turning sheet under the client's head to midthigh to reposition in bed—CORRECT: using a turning sheet under the client's head to midthigh helps move the client as a unit maintaining body alignment, and reducing the risk for increased ICP

52. The Answer is 2

A pediatric client with a congenital heart disorder is admitted with heart failure. Digoxin 0.12 mg by mouth daily is ordered for the client. The bottle contains 0.05 mg of digoxin in 1 mL of solution. Which of the following amounts should the LPN/LVN administer to the client after validating the dose with the RN?

Reworded Question: How much of the medication should you give?

Strategy: Remember how to calculate dosages. Be careful and don't make math errors.

Needed Info: Formula: dose on hand over 1 mL = dose desired.

Category: Implementation/Physiological Integrity/Pharmacological Therapies

1.2 mL—inaccurate

2.4 mL—CORRECT:  $0.05 \text{ mg}/1 \text{ mL} = 0.12 \text{ mg}/x \text{ mL}$ ,  $0.05x = 0.12$ ,  $x = 2.4 \text{ mL}$

3.5 mL—inaccurate

4.2 mL—inaccurate

53. The Answer is 4

The LPN/LVN is caring for a client diagnosed with chronic lymphocytic leukemia, hospitalized for treatment of hemolytic anemia. The LPN/LVN should expect to implement which of the following actions?

Reworded Question: What should you do for a client with anemia?

Strategy: Although the client has leukemia, he is admitted with anemia. You must focus on the anemia.

Needed Info: Lymphocytic leukemia: characterized by proliferation of lymphocytes. S/S: fatigue, weakness, hemolytic anemia, easy bruising, bleeding gums, epistaxis, fever, generalized pain. Diagnostic tests: CBC, bone marrow aspiration, lumbar puncture, x-rays, lymph node biopsy. Treatment: total body irradiation or radiation to spleen, chemotherapy.

Nursing responsibilities: low-bacteria diet (no raw fruits or vegetables), institute bleeding precautions (soft toothbrush, don't floss, no injections, no aspirin, pad bed rails, use air mattress, use paper tape), antiemetics, comfort measures. Hemolytic anemia S/S: jaundice, splenomegaly, hepatomegaly, fatigue, weakness. Treatment: O<sub>2</sub>, blood transfusions, corticosteroids.

Category: Planning/Physiological Integrity/Physiological Adaptation

Encourage activities with other clients in the day room—does not meet need for rest

Isolate the client from visitors and clients to avoid infection—no information given about white blood cell count; protective isolation for neutrophil count less than 500/mm<sup>3</sup>

Provide a diet that contains foods that are high in vitamin C—needed for wound healing and resistance to infection; not best choice

Maintain a quiet environment to promote adequate rest—  
CORRECT: primary problem activity intolerance due to fatigue

54. The Answer is 3

The LPN/LVN is caring for a client with cervical cancer. The LPN/LVN notes that the radium implant has become dislodged. Which of the following actions should the LPN/LVN take first?

Reworded Question: What is the best action when a radium implant becomes dislodged?

Strategy: Think about the outcome of each answer choice.

Needed Info: Limit radioactive exposure: assign client to private room; place “Caution: Radioactive Material” sign on door; wear dosimeter film badge at all times when interacting with client (measures amount of exposure); do not assign pregnant health care worker to client; rotate staff caring for client; organize tasks so limited time is spent in client’s room; limit visitors; encourage client to do own care; provide shield in room. Client care: use antiemetics for nausea; consider body image; provide comfort measures; provide good nutrition.

Category: Implementation/Physiological Integrity/Reduction of Risk Potential

Grasp the implant with a sterile hemostat and carefully reinsert it into the client—the implant should be picked up with long-handled forceps, not a hemostat, and deposited into a lead container in the room, not reinserted into the client

Wrap the implant in a blanket and place it behind a lead shield until reimplantation—the implant should be picked up with long-handled forceps and put into a lead container in the room for disposal

Ensure the implant is picked up with long-handled forceps and placed in a lead container—CORRECT: the priority is to secure the implant to prevent unwanted and dangerous radiation exposure; the implant should be picked up with long-handled forceps and then placed in a lead container; this equipment should be kept in the room of any client receiving this therapy so that it is readily available; institutional guidelines and procedures for managing dislodgement should be followed; radiology is usually involved as soon as dislodgement occurs

Obtain a dosimeter reading on the client and report it to the primary health care provider—need to place implant in lead container

55. The Answer is 2

The LPN/LVN comes to the home of a client with cellulitis of the left leg to perform a daily dressing change. The client tells the LPN/LVN that the unlicensed assistive personnel (UAP) changed the dressing earlier that morning. Which of the following actions by the LPN/LVN is best?

Reworded Question: What is the correct chain of command for reporting a problem?

Strategy: Think about the chain of command.

Category: Implementation/Safe and Effective Care  
Environment/Coordinated Care

Tell the client that the new dressing looks fine—does not address the problem of the UAP performing the dressing change

Notify the RN supervisor of the situation—CORRECT: correct follow the chain of command for reporting this problem

Ask the client to describe the dressing change—does not address the problem of the UAP performing the dressing change

Report the UAP to the home care agency—incorrect chain of command; should report problem to next person in direct line of authority in same area

56. The Answer is 1



The LPN/LVN is caring for a client with pernicious anemia. The LPN/LVN reinforces teaching about the plan of care. The LPN/LVN should report which of the following statements to the RN?

Reworded Question: What is true about pernicious anemia?

Strategy: Determine the outcome of each answer choice.

Needed Info: Pernicious anemia is caused by failure to absorb vitamin B<sub>12</sub> because of a deficiency of intrinsic factor from the gastric mucosa. Symptoms: pallor, slight jaundice, glossitis, fatigue, weight loss, paresthesias of hands and feet, disturbances of balance and gait. Treatment: vitamin B<sub>12</sub> IM monthly.

Category: Evaluation/Physiological Integrity/Physiological Adaptation

“In order to get better, I will take iron pills.”—CORRECT: pernicious anemia is due to vitamin B deficiency, not iron deficiency

“I will attend smoking cessation classes.”—no reason to report

“I will learn how to perform IM injections.”—many clients instructed how to give monthly IM B<sub>12</sub> injection

“I will make sure to eat a well-balanced diet.”—no reason to report

57. The Answer is 2

The LPN/LVN is caring for clients on a general medical/surgical unit of an acute care facility. Four clients have been admitted in the last 20 minutes. Which of the admissions should the LPN/LVN see first?

Reworded Question: Who is the priority client?

Strategy: Think ABCs.

Needed Info: Factors to consider: chief complaint; age of client; medical history; potential for life-threatening event.

Category: Planning/Physiological Integrity/Reduction of Risk Potential

A client reporting vomiting and diarrhea—airway issue takes priority

A client with third-degree burns to face—CORRECT: face, neck, chest, or abdominal burns can cause severe edema that restricts the airway; airway issues take priority

A client with a fractured left hip—airway issue takes priority

A client reporting epigastric pain—airway issue takes priority

58. The Answer is 4

The LPN/LVN is caring for a client with a diagnosis of chronic bronchitis. The client has audible wheezing, and an oxygen saturation of 85%. Four hours ago, the oxygen saturation was 88%. It is most important for the LPN/LVN to take which of the following actions?

Reworded Question: What is the best action for a client with COPD?

Strategy: Determine the outcome of each answer choice.

Needed Info: Chronic bronchitis: predisposing factors include smoking, chronic infections, environmental pollution. Teaching reinforcement includes breathing exercises; stop smoking; avoid hot and cold air or allergens; instructions regarding medications; avoid crowds or close

contact with persons who have colds or influenza; adequate rest and nutrition; oral hygiene; influenza vaccines; observe sputum for indications of infection.

Category: Implementation/Physiological Integrity/Pharmacological Therapies

Give beclomethasone, 2 puffs via metered-dose inhaler—administer bronchodilator first to open passageways

Auscultate the client's bilateral breath sounds—situation does not require further data collection

Increase oxygen flow rate to 4L/minute via mask—increasing the client's blood oxygen level may cause respiratory depression

Administer albuterol, 2 puffs via metered-dose inhaler—CORRECT: a bronchodilator, such as albuterol relaxes bronchial smooth muscles and increases airflow to the lungs.

59. The Answer is 4

The LPN/LVN is caring for a client hospitalized for observation following a fall. The client states, “My friend fell last year, and no one thought anything was wrong. She died 2 days later!” Which of the following responses by the LPN/LVN is best?

Reworded Question: What is the most therapeutic response?

Strategy: Remember therapeutic communication.

Needed Info: Therapeutic communication: using silence (allows client time to think and reflect; conveys acceptance; allows client to take lead

in conversation); using general leads or broad openings (encourages client to talk, indicates interest in client); clarification (encourages description of feelings and details of particular experience; makes sure LPN/LVN understands client); reflecting (paraphrases what client says; reflects what client says, especially feelings conveyed).

Category: Implementation/Psychosocial Integrity

“This happens to quite a few people.”—nontherapeutic; doesn’t address client’s concerns

“We are monitoring you, so you’ll be okay.”—nontherapeutic; “don’t worry” response

“Don’t you think I’m taking good care of you?”—nontherapeutic; focus is on the LPN/LVN

“You’re concerned that it might happen to you?”—CORRECT: reflects client’s feelings

60. The Answer is 2

The LPN/LVN is caring for clients on the pediatric unit. A client with second- and third-degree burns on the right thigh is being admitted. The LPN/LVN should expect the new client to be placed with which one of the following roommates?

Reworded Question: Who is the appropriate roommate for a client with burns?

Strategy: Think about the transmission of diseases.

Needed Info: Burns: increase the risk for infection; contact precautions to prevent spread of pathogens transmitted by direct contact or contact with items in the client's environment, such organisms as *Clostridium difficile* and methicillin-resistant *Staphylococcus aureus*; airborne and contact precautions required until chickenpox lesions become dry and crusted.

Category: Implementation/Physiological Integrity/Physiological Adaptation

A client with chickenpox—infectious disease requires airborne and contact precautions

A client with asthma—CORRECT: lowest risk of cross-contamination because client is not infectious

A client who developed acute diarrhea after antibiotic—requires contact precautions because the client may have *Clostridium difficile* diarrhea

A client with methicillin-resistant *Staphylococcus aureus* — requires resistant organism requires contact precautions

61. The Answer is 2

To evaluate the effectiveness of a client's heparin therapy, the LPN/LVN should monitor which of the following laboratory values?

Reworded Question: What blood work is done to monitor heparin therapy?

Strategy: Remember what information is most important for a client receiving heparin therapy.

Needed Info: Heparin: anticoagulant. Side effects: hemorrhage, thrombocytopenia. Antidote: protamine sulfate. When given subcutaneously, inject slowly; leave needle in place 10 seconds, then withdraw; don't massage site; rotate sites. Nursing responsibilities: check for bleeding gums, bruises, nosebleeds, petechiae, melena, tarry stools, hematuria; use electric razor and soft toothbrush.

Category: Data Collection/Physiological Integrity/Reduction of Risk Potential

Platelet count—evaluates platelet production; not altered

Clotting time—CORRECT: or partial thromboplastin time; 1.5–2 times control, clotting time 2–3 times control

Bleeding time—duration of bleeding after small puncture wound; detects platelet and vascular problems; not altered

Prothrombin time—used to monitor warfarin therapy

62. The Answer is 3

The LPN/LVN is reinforcing teaching with a client who is scheduled for a paracentesis. Which of the following statements by the client indicates that teaching has been successful?

Reworded Question: What is a correct statement about paracentesis?

Strategy: Determine the outcome of each answer choice.

Needed Info: Paracentesis: removal of fluid from the peritoneal cavity; 2–3 L may be removed. Preparation: informed consent; void, obtain vital signs; measure abdominal girth; weigh client. During procedure:

frequently monitor vital signs. After procedure: document amount, color, characteristics of drainage obtained; assess pressure dressing for drainage; position in bed until vital signs stabilize.

Category: Evaluation/Physiological Integrity/Reduction of Risk Potential

“I will be in surgery for less than an hour.”—not a surgical procedure

“I must not void prior to the procedure.”—bladder is emptied prior to the procedure to prevent puncture

“Two to 3 liters of fluid will be removed.”—CORRECT: primary health care provider slowly removes 2 to 3 liters of fluid to decrease ascites; in severe cases, can remove up to 6 liters

“I will lie on my back and breathe slowly.”—positioned in an upright position with feet supported for the procedure

63. The Answer is 2

The LPN/LVN is performing chest physiotherapy on a client with chronic airflow limitations (CAL). Which of the following actions should the nurse take first?

Reworded Question: What should the LPN/LVN do prior to beginning chest physiotherapy?

Strategy: Determine whether to collect data or implement.

Needed Info: Postural drainage: uses gravity to facilitate removal of bronchial secretions; client is placed in a variety of positions to facilitate drainage into larger airways; secretions may be removed by coughing or

suctioning. Percussion and vibration: augments the effect of gravity during postural drainage; percussion: rhythmic striking of chest wall with cupped hands over areas where secretions are retained; vibration: hand and arm muscles of person doing vibration are tensed, and a vibrating pressure is applied to chest as client exhales.

Category: Data Collection/Physiological Integrity/Reduction of Risk Potential

Perform chest physiotherapy prior to meals—prevents nausea, vomiting, aspiration

Auscultate breath sounds before the procedure—CORRECT: helps identify areas of the lung that require drainage; auscultate breath sounds after the procedure to determine effectiveness

Administer bronchodilators after the procedure—given before chest physiotherapy to dilate the bronchioles and to liquify secretions

Percuss each lobe prior to asking the client to cough—may cause fractures of the ribs; percussion helps loosen thick secretions

64. The Answer is 2

In which of the following situations would it be most appropriate for the LPN/LVN to wear a gown and gloves?

Reworded Question: Which of these clients poses the greatest risk for spreading disease, requiring the use of gloves and a gown?

Strategy: Note how microorganisms are most frequently spread.



Needed Info: Spread of microorganisms: contact directly with a source of infection, contact with surfaces contaminated with microorganisms, some airborne diseases, includes all bodily waste and fluids except sweat. Standard precautions: Centers for Disease Control and Prevention (CDC) recommends barrier techniques to prevent spread of microorganisms; common barriers include gloves, masks, goggles, and gowns; choose appropriate barrier for the situation.

Category: Implementation/Safe and Effective Care Environment/Safety and Infection Control

Administering oral medications to a client with with human immunodeficiency virus disease—there is no contact with blood or other potentially infectious body fluids

Assisting in the care of a motor vehicle accident victim who continues to bleed—CORRECT: blood from this client may contact the LPN/LVN's skin when performing care or gathering data; gloves protect hands and gowns protect the skin from exposure to blood and body fluids

Bathing a client with an abdominal wound infection—gloves provide adequate protection

Changing the linen of a client with sickle-cell anemia—if bed is soiled, gloves should provide adequate protection; linen should not be in contact with the LPN/LVN's uniform

65. The Answer is 2

A client is receiving 1,000 mL of 5% dextrose in half normal saline solution IV to infuse over 8 hours. The IV administration set tubing

delivers 15 drops per milliliter. The LPN/LVN should expect the flow rate to be how many drops per minute?

Reworded Question: What is the correct IV flow rate?

Strategy: Use the correct formula and be careful not to make math errors.

Needed Info: Formula: total volume  $\times$  drip factor divided by the total time in minutes.

Category: Planning/Physiological Integrity/Pharmacological Therapies

15—incorrect

31—CORRECT:  $(1,000 \times 15)$  divided by  $(8 \times 60)$

45—incorrect

60—incorrect

66. The Answer is 3

A client is admitted to the hospital reporting seizures and a high fever. A positron emission tomography (PET) brain scan is prescribed. Before the PET brain scan, the client asks the LPN/LVN what position is necessary for the test. Which of the following statements by the LPN/LVN is most accurate?

Reworded Question: What is the proper position for a PET brain scan?

Strategy: Visualize the procedure.

Needed Info: PET brain scan: measures amount of uptake by the brain of radioactive isotopes. Damaged tissue absorbs more than normal tissue. Nursing care before: withhold medications (antihypertensives, vasoconstrictors, vasodilators for 24 hours). Test is painless. After test, force fluids to promote excretion of isotopes. Urine doesn't need special handling.

Category: Implementation/Physiological Integrity/Reduction of Risk Potential

“You will be in a side-lying position, with the foot of the bed elevated.”—incorrect

“You will be in a semi-upright sitting position, with your knees flexed.”—incorrect

“You will be lying on your back with a small pillow under your head.”—CORRECT

“You will be flat on your back, with your feet higher than your head”—incorrect

67. The Answer is 2

A client with a diagnosis of delirium is admitted to the hospital. Blood samples are sent to the laboratory to help determine the underlying cause. Laboratory test results include: sodium 156 mEq/L (156 mmol/L), chloride 100 mEq/L (100 mmol/L), potassium 4 mEq/L (4 mmol/L), bicarbonate 21 mEq/L (21 mmol/L), blood urea nitrogen (BUN) 86 mg/dL (30.7 mmol/L), glucose 100 mg/dL (5.5 mmol/L). Based on these laboratory results, the LPN/LVN would expect to see which of the following nursing diagnoses on the client's care plan?

Reworded Question: What nursing diagnosis is appropriate?

Strategy: Determine if each laboratory test result is normal or abnormal. Decide what the abnormal laboratory test results indicate about the client and how it would influence the appropriate nursing diagnosis for that client.

Needed Info: Normal sodium: 135–145 mEq/L (135–145 mmol/L). Hypernatremia: dehydration and insufficient water intake. Normal chloride: 95–105 mEq/L (95–105 mmol/L). Normal potassium: 3.5–5 mEq/L (3.5–5 mmol/L). Normal bicarbonate: 22–26 mEq/L (22–26 mmol/L). Decreased levels seen with starvation, acute kidney injury, diarrhea. Normal: BUN 6–20 mg/dL (2.1–7.4 mmol/L). Elevated levels indicate rapid protein catabolism, kidney dysfunction, dehydration. Normal glucose: 70–100 mg/dL (3.9–5.5 mmol/L).

Category: Planning/Physiological Integrity/Reduction of Risk Potential

Alteration in patterns of urinary elimination—would have altered potassium level

Fluid volume deficit—CORRECT: elevated sodium level, decreased bicarbonate level, elevated BUN, other values are normal; elevated sodium and BUN levels seen with dehydration

Nutritional deficit: less than body requirements—would have altered potassium level

Self-care deficit: feeding—no information to support this

68. The Answer is 3

A client is to receive 3,000 mL of normal saline solution IV to infuse over 24 hours. The IV administration set delivers 15 drops per milliliter. The LPN/LVN would expect the flow rate to be how many drops of fluid per minute?

Reworded Question: What should the IV flow rate be?

Strategy: Use the formula and avoid making math errors.

Needed Info: Total volume  $\times$  the drop factor divided by the total time in minutes

Category: Planning/Physiological Integrity/Pharmacological Therapies

21—inaccurate

28—inaccurate

31—CORRECT:  $(3,000 \times 15)$  divided by  $(24 \times 60)$

42—inaccurate

69. The Answer is 4

The LPN/LVN is caring for a client diagnosed with asthma. The primary health care provider prescribes neostigmine IM. Which of the following actions by the LPN/LVN is most appropriate?

Reworded Question: Can neostigmine be administered to a client with asthma?

Strategy: “Most appropriate” indicates that discrimination is required to answer the question.

Needed Info: Neostigmine: parasympathomimetic used to treat myasthenia gravis and as an antidote for nondepolarizing neuromuscular blocking agents; potentiates the action of morphine; side effects include nausea, vomiting, abdominal cramps, respiratory depression, bronchoconstriction, hypotension, and bradycardia; nursing considerations include monitor vital signs frequently, have atropine injection available, take with milk.

Category: Evaluation/Physiological Integrity/Reduction of Risk Potential

Administer the medication, as prescribed—causes bronchoconstriction; notify the primary health care provider

Obtain the client's blood pressure and pulse—data collection; neostigmine causes hypotension and bradycardia; important to monitor vital signs, but priority is to notify the supervising RN or primary health care provider because medication can precipitate an acute exacerbation of asthma

Ask pharmacist if the medication can be given orally—medication used cautiously for clients with asthma

Notify the primary health care provider—CORRECT: cholinergics can cause bronchoconstriction in asthmatic clients; may precipitate an acute exacerbation of asthma

70. The Answer is 4

The LPN/LVN is caring for a client with a history of Addison's disease who has received steroid therapy for several years. The LPN/LVN would expect the client to exhibit which of the following changes in appearance?

Reworded Question: What changes are seen in a client after taking steroids long-term?

Strategy: All the options in an answer choice must be correct for the option to be right.

Needed Info: Medications: cortisone and hydrocortisone usually given in divided doses: 2/3 in morning and 1/3 in late afternoon with food to decrease GI irritation. Reinforce teaching to report S/S of excessive drug therapy (rapid weight gain, round face, fluid retention).

Category: Data Collection/Physiological Integrity/Physiological Adaptation

Buffalo hump, girdle-obesity, gaunt facial appearance—buffalo hump and girdle-obesity true with long-term steroid use; gaunt face seen with lack of steroids

Skin tanning, mucous membrane discoloration, weight loss—tanning and weight loss seen with lack of steroids; mucous membrane discoloration not seen

Emaciation, nervousness, breast engorgement, hirsutism—nothing to do with steroids; hirsutism: excessive growth of hair

Truncal obesity, purple striations on the skin, moon face—  
CORRECT: effects of excess glucocorticoids

71. The Answer is 1

The LPN/LVN is caring for a client with a history of pancreatic cancer who appears jaundiced. The LPN/LVN should give the highest priority to which of the following needs?

Reworded Question: What is the highest priority for a client with pancreatic cancer?

Strategy: Remember Maslow.

Needed Info: Medical treatment: high-calorie, bland, low-fat diet; small, frequent feedings; avoid alcohol; anticholinergics; antineoplastic chemotherapy

Category: Planning/Physiological Integrity/Reduction of Risk Potential

Nutrition—CORRECT: profound weight loss and anorexia occur with pancreatic cancer

Self-image—a client who appears jaundiced clients may be concerned about personal appearance, but physiological needs take priority

Skin integrity—jaundice causes dry skin and pruritis; scratching can lead to skin breakdown

Urinary elimination—obstructive process caused by pancreatic cancer darkens urine; kidney function is not affected

72. The Answer is 1

An pediatric is seen in a clinic for treatment of attention-deficit/hyperactivity disorder (ADHD). Medication has been prescribed for the client along with family counseling. The LPN/LVN reinforces the teaching plan about the medication and discusses parenting strategies with the parents. Which of the following statements by the parents indicates that further teaching is necessary?



Reworded Question: What information is wrong for a child with ADHD?

Strategy: Be careful! You are looking for incorrect information.

Needed Info: ADHD: developmentally inappropriate inattention, impulsivity, hyperactivity. Treatment: medication, family counseling, remedial education, environmental manipulation (decrease external stimuli), psychotherapy.

Category: Evaluation/Psychosocial Integrity

“We will give the medication at night so it doesn’t decrease appetite.”—CORRECT: incorrect information; stimulants used; side effects: insomnia, palpitations, growth suppression, nervousness, decreased appetite; give 6 hours before bedtime

“We will provide a regular routine for sleeping, eating, working, and playing.”—true

“We will establish firm but reasonable limits on behavior.”—true

“We will reduce distractions and external stimuli to help concentraton.”—true

73. The Answer is 4

The client diagnosed with anorexia nervosa is admitted to the hospital. Which of the following statements by the client requires immediate follow-up by the LPN/LVN?

Reworded Question: Which problem has the highest priority for this client?

Strategy: Remember Maslow's hierarchy of needs.

Needed Info: Anorexia nervosa: a disorder characterized by restrictive eating resulting in emaciation, disturbance in body image, and an intense fear of being obese. Physical needs must be met first to maintain the client in stable condition. Adequate fluid and electrolyte balance are difficult to maintain.

Category: Planning/Psychosocial Integrity

“My gums bled this morning.”—vitamin deficiencies may cause bleeding gums, but not the highest priority

“I’m getting fatter every day.”—body image disturbance occurs in client's diagnosed with anorexia nervosa, but such psychosocial needs do not take priority

“Nobody likes me, I’m so ugly.”—chronic low self-esteem commonly occurs with anorexia nervosa; this psychosocial need does not take priority

“I’m feel dizzy and weak today.”—CORRECT: fluid volume deficit takes highest priority; dehydration, a common occurrence with anorexia nervosa, could lead to irreversible kidney damage and vital sign instability

74. The Answer is 4

A client is admitted to the hospital for treatment of Pneumocystis jiroveci pneumonia and Kaposi's sarcoma. The client informs the LPN/LVN about a personal decision to become an organ donor. Which of the following responses by the LPN/LVN is best?

Reworded Question: Can this client be an organ donor?

Strategy: Think about each answer choice.

Needed Info: Criteria for organ and tissue donation: no history of significant disease process in organ or tissue to be donated; no untreated sepsis; brain death of donor; no history of extracranial malignancy; relative hemodynamic stability; blood group compatibility; newborn donors must be full-term (more than 200 g); only absolute restriction to organ donation is documented case of human immunodeficiency virus (HIV) disease. Family members can give consent. Nurse can discuss organ donation with other death-related topics (funeral home to be used, autopsy request).

Category: Implementation/Physiological Integrity/Physiological Adaptation

“What does your family think about your decision?”—client has the right to make the decision

“You will help many people by donating your organs.”—clients with documented HIV disease are prohibited from donating organs

“Would you like to speak to the organ donor coordinator?”—passes responsibility for the discussion to the organ donor coordinator

“Your illness prevents you from becoming an organ donor.”—  
CORRECT: clients with documented HIV disease are prohibited from donating organs

The LPN/LVN is caring for a client 2 days after a pancreatectomy for cancer of the pancreas. The LPN/LVN observes minimal drainage from the nasogastric (NG) tube. It is most important for the LPN/LVN to take which of the following actions?

Reworded Question: What is the best action when an NG tube is not draining?

Strategy: Determine whether it is appropriate to collect data or implement.

Needed Info: Insertion of NG sump: measure distance from tip of nose to earlobe, plus distance from earlobe to bottom of xyphoid process. Mark distance on tube with tape and lubricate end of tube. Insert tube through nose to stomach. Offer sips of water and advance tube gently; bend head forward. Observe for respiratory distress. Secure with hypoallergenic tape or securement device. Verify tube position initially and before feeding. Aspirate for gastric contents and check appearance and pH.

Category: Data Collection/Physiological Integrity/Basic Care and Comfort

Notify primary health care provider—should collect data first  
Monitor vital signs every 15 minutes—does not address lack of drainage

Check the NG tube for kinking—CORRECT: collect data prior to implementing; maintain tubing in a dependent position to promote drainage

Replace the NG tube immediately—collect data before implementing

76. The Answer is 3

The LPN/LVN is planning to administer furosemide 20 mg PO to a client diagnosed with chronic kidney disease. The client asks the LPN/LVN the reason for receiving this medication. Which of the following responses by the LPN/LVN is best?

Reworded Question: Why is furosemide given to a client diagnosed with stage?

Strategy: Think about the action of furosemide.

Needed Info: Chronic kidney disease is progressive, irreversible kidney damage that can be caused by hypertension, diabetes mellitus, lupus erythematosus, or chronic glomerulonephritis; symptoms include anemia, acidosis, azotemia, fluid retention, and urinary output alterations; nursing care includes monitoring potassium levels, daily weight, intake and output, dietary teaching about regulating protein intake, fluid intake to balance fluid losses, and some restrictions of sodium and potassium.

Category: Implementation/Physiological Integrity/Reduction of Risk Potential

“To increase the blood flow to your kidney.”—Furosemide is a loop diuretic that inhibits sodium and chloride reabsorption at the proximal and distal tubules and the ascending loop of Henle

“To decrease your circulating blood volume.”—Furosemide used to treat fluid overload due to chronic kidney disease

“To increase excretion of sodium and water.”—CORRECT: nursing considerations when administering furosemide include monitoring blood pressure, measuring intake and output, monitoring potassium levels; don’t give at hour of sleep

“To decrease the workload on your heart.”—correcting the fluid overload will decrease the workload on the heart, but the primary reason furosemide is given to clients diagnosed with chronic kidney disease is to augment the kidney’s functioning

#### 77. The Answer is 1

The LPN/LVN is reinforcing discharge teaching for a client with Parkinson’s disease. To maintain safety, the LPN/LVN should make which of the following suggestions to the family?

Reworded Question: What is a correct client teaching for Parkinson’s disease?

Strategy: Determine the outcome of each answer choice.

Needed Info: Symptoms: tremors, akinesia, rigidity, weakness, motorized propulsive gait, slurred monotonous speech, dysphagia, drooling, mask-like expression. Nursing care: Encourage finger exercises. Administer antiParkinson's medications. Reinforce teaching of client ambulation modification. Promote family understanding of the disease (intellect/sight/hearing not impaired, disease progressive but slow, doesn’t lead to paralysis). Refer for speech therapy, potential stereotactic surgery.

Category: Implementation/Physiological Integrity/Basic Care and Comfort

Install a raised toilet seat—CORRECT: helps client maintain independence

Obtain a hospital bed—no indications that this is needed

Instruct client to hold arms dependently during ambulation—client should swing arms to maintain balance when walking

Participate in an exercise program during the late afternoon—activities should be scheduled for late morning when energy level peaks

78. The Answer is 3

The LPN/LVN is reinforcing discharge teaching for a client with chronic pancreatitis. Which of the following statements by the client indicates that further teaching is necessary?

Reworded Question: What is an incorrect statement about pancreatitis?

Strategy: This is a negative question; you are looking for incorrect information.

Needed Info: Plan/implementation: nothing by mouth (NPO), gastric decompression. Medications: antacids, analgesics, antibiotics, anticholinergics. Maintain fluid/electrolyte balance. Monitor for signs of infection. Cough and deep-breathe; semi-Fowler's position. Monitor for shock and hyperglycemia. Treatment of exocrine insufficiency: medications containing amylase, lipase, trypsin to aid digestion. Long-

term: avoid alcohol; low-fat, bland diet; small, frequent meals. Monitor S/S of diabetes mellitus.

Category: Evaluation/Physiological Integrity/Reduction of Risk Potential

“I do not have to restrict physical activity.”—no specific restrictions on activity

“I should take pancrelipase before meals.”—pancreatic enzyme replacement should be taken before or with meals

“I will eat three large meals every day.”—CORRECT: small, frequent feedings are most beneficial with chronic pancreatitis

“I am not allowed to drink any alcoholic beverages.”—chronic pancreatitis requires complete abstinence from alcohol

79. The Answer is 3

After a laparoscopic cholecystectomy, the client reports abdominal pain and bloating. Which of the following responses by the LPN/LVN is best?

Reworded Question: What is the best intervention for a client reporting free air pain?

Strategy: “Best” indicates there may be more than one response that appears correct.

Needed Info: Cholecystectomy: removal of gallbladder. T-tube inserted to ensure drainage of bile from common bile duct until edema diminishes. Check amount of drainage (usually 500–1,000 mL/day, decreases as fluid begins to drain into duodenum). Protect skin around incision from bile drainage irritation (use zinc oxide or water-soluble



lubricant). Keep drainage bag at same level as gallbladder. Maintain client in semi-Fowler's position after T-tube removal; observe dressing for bile; notify primary health care provider for significant drainage. Evaluate pain to check for other problems. Monitor for signs of potassium and sodium loss; flattened or inverted T-waves on electrocardiogram; muscle weakness; abdominal distension; headache; apathy; nausea or vomiting; jaundice.

Category: Implementation/Physiological Integrity/Physiological Adaptation

“Increase intake of fresh fruits and vegetables”—no indication of constipation

“I'll give you the prescribed pain medication.”—laparoscopic procedure requires less pain medication than open cholecystectomy

“Why don't you take a walk down the hallway?”—CORRECT: carbon dioxide insufflated during laparoscopic surgery causes pain; ambulation increases absorption and decreases pain

“You may need an indwelling urinary catheter.”—carbon dioxide insufflated during laparoscopic surgery causes pain; an indwelling urinary catheter does not relieve associated pain

80. The Answer is 3

The nursing team consists of an RN, two UAPs, and an LPN/LVN. The LPN/LVN would expect to be assigned to which of the following clients?

Reworded Question: What is a correct client assignment for an LPN/LVN?

Strategy: Think about each answer.

Needed Info: LPN/LVNs care for stable clients with predictable outcomes. Unlicensed assistive personnel (UAPs) perform standard, unchanging procedures.

Category: Implementation/Safe and Effective Care  
Environment/Coordinated Care

A client scheduled for an MRI of the brain—requires assessment and teaching; should be cared for by RN

An unconscious client who requires a bed bath—bed bath for an unconscious client can be assigned to the UAP

A client in balanced suspension traction—CORRECT: LPN/LVN must care for client; collect data on client airway, adequate respirations, and circulatory status

A client with diabetes who needs help bathing—UAP can assist with bath

81. The Answer is 125

The primary health care provider orders 1 L dextrose 5% in half normal saline solution IV to infuse over 8 hours. The drip factor stated on the IV administration set tubing is 15 gtt/mL. How many milliliters should the LPN/LVN expect to be infused every hour?

Reworded Question: How much fluid needs to infuse every hour to infuse 1,000 mL in 8 hours?

Strategy: Think about the question being asked. Note that there is unnecessary information provided.

Needed Info: One liter is equal to 1,000 milliliters. Dividing the total amount of fluids to infuse by the number of hours in which the infusion should be completed equals hourly fluid amounts.

Category: Planning/Physiological Integrity/Pharmacological Therapies

1 liter = 1,000 mL;  $1,000 \text{ mL} / 8 \text{ hours} = 125 \text{ mL/hour}$

The correct answer is 125.

82. The Answer is 1

A client underwent vagotomy with antrectomy for treatment of a duodenal ulcer. Postoperatively, the client develops dumping syndrome. Which of the following statements by the client indicates to the LPN/LVN that further dietary teaching is necessary?

Reworded Question: What is contraindicated for the client with dumping syndrome?

Strategy: Be careful! You are looking for incorrect information.

Needed Info: Antrectomy: surgery to reduce acid-secreting portions of stomach. Delays or eliminates gastric phase of digestion. Dumping syndrome occurs in clients after a gastric resection. It occurs after eating and is related to the stomach's reduced capacity. Undigested food is dumped into the jejunum resulting in distention, cramping, pain, diarrhea 15–30 minutes after eating. Subsides in 6–12 months. S/S 5–30 minutes after eating: vertigo, tachycardia, syncope, diarrhea, nausea. Treatment: sedatives, antispasmodics, high-protein, high-fat, low-

carbohydrate, dry diet. Eat in semirecumbent position, lying down after eating.

Category: Evaluation/Physiological Integrity/Reduction of Risk Potential

“I should eat bread with each meal.”—CORRECT: incorrect information; should decrease intake of carbohydrates

“I should eat smaller meals more frequently.”—true; 5 to 6 small meals

“I should lie down right after eating.”—true; delays gastric emptying time

“I should avoid drinking fluids with my meals.”—true; no fluids 1 hour before, with, or 2 hours after meal

83. The Answer is 3

The LPN/LVN reinforces discharge teaching with a client with emphysema. Which of the following statements by the client indicates that teaching was successful?

Reworded Question: What is true about emphysema?

Strategy: Determine the outcome of each answer choice.

Needed Info: Emphysema: chronic progressive respiratory disease caused by destruction of alveolar walls. Complications: acute respiratory infections, heart failure or cor pulmonale, cardiac dysrhythmias. Symptoms: cough, dyspnea, wheezing, barrel chest, use of accessory muscles to breathe. Treatment: bronchodilators,

corticosteroids, cromolyn sodium, oxygen, diaphragmatic and pursed-lip breathing maneuvers, energy conservation, diet therapy.

Category: Evaluation/Physiological Integrity/Physiological Adaptation

“Cold weather should help my breathing problems.”—can exacerbate breathing problems by causing bronchospasms

“I’ll eat three balanced meals daily but limit my fluid intake.”—small, frequent meals should be consumed to increase caloric intake, limit shortness of breath caused by eating; fluids should not be limited because hydration liquefies secretions

“I’ll limit my outside activity when pollution levels are high.”—CORRECT: pollution acts as irritant by causing bronchospasms

“Intensive exercise should help me regain strength.”—intensive exercise is not tolerated; a conditioning program can help conserve and increase pulmonary ventilation

84. The Answer is 3

A client has been taking aluminum hydroxide daily for 3 weeks. The LPN/LVN should be alert for which of the following side effects?

Reworded Question: What is a side effect of aluminum hydroxide?

Strategy: Remember common side effects.

Needed Info: Aluminum hydroxide: antacid that reduces the total amount of acid in the GI tract and elevates the gastric pH level. May cause hypophosphatemia. Shake suspension well and give with milk or water.

Category: Data Collection/Physiological Integrity/Pharmacological Therapies

Nausea—not common

Hypercalcemia—seen with calcium-containing antacids; normal calcium 8.5–10.5 mg/dL (2.3–2.6 mmol/L)

Constipation—CORRECT: may need laxatives or stool softeners

Anorexia—not common

85. The Answer is 3

The LPN/LVN is hearing a client call for help. The LPN/LVN enters the room and finds a client in bilateral wrist restraints with a cool, pale right hand and no palpable radial pulse. Which of the following would be the most appropriate action for the LPN/LVN to take first?

Reworded Question: What is the priority response to this situation?

Strategy: Think ABCs and about the risk restraints pose to circulation.

Needed Info: Loss of circulation: loss of all or part of a limb can occur in as little as 15 minutes when blood flow is absent.

Category: Planning/Safe and Effective Care Environment/Safety and Infection Control

Leave to find the client's nurse—this delays the immediate intervention required to protect the hand

Massage the client's wrist and hand—does not address the cause of the impaired hand circulation, delays intervention

Remove the right wrist restraint—CORRECT: provides the most immediate and effective way to help return circulation to the wrist and hand; the LPN/LVN can call for help and turn on the client's call light for further assistance and assessment

Reposition the client to reduce pressure—does not address the cause of the impaired hand circulation, delays intervention

86. The Answer is 4

The LPN/LVN is reinforcing discharge teaching for a client with a new colostomy. The LPN/LVN knows teaching was successful when the client chooses which of the following menu options?

Reworded Question: What is the appropriate diet for a client with a colostomy?

Strategy: Recall the type of diet required and then select the menu that is appropriate.

Needed Info: Diet: a low-residue diet for 4–6 weeks postoperatively, avoiding gas-forming, odor-producing, or excessively laxative or constipating foods.

Category: Evaluation/Physiological Integrity/Reduction of Risk Potential

Sausage, sauerkraut, baked potato, and fresh fruit—sausage and sauerkraut are gas-producing and should be avoided with a new colostomy

Cheese omelet with bran muffin and fresh pineapple—bran muffin and fresh fruit are high-fiber (residue)

Pork chop, mashed potatoes, turnips, and salad—turnips are odor-causing and salad is high-residue

Baked chicken, boiled potato, cooked carrots, and yogurt—  
CORRECT: provides balanced nutrition, high protein, low residue, low fat, and nonirritating foods

87. The Answer is 4

A client is admitted to the unit with suspected acute kidney injury. The LPN/LVN would be most concerned if the client made which of the following statements?

Reworded Question: What is a symptom of acute renal failure?

Strategy: “Most concerned” indicates you are looking for a symptom of acute kidney injury.

Needed Info: Symptoms of oliguric phase of acute kidney injury: urinary output less than 400 mL/day; irritability, drowsiness, confusion, coma; restlessness, twitching, seizures; hyperkalemia, increased blood urea nitrogen (BUN) and creatinine levels, hypercalcemia, hypernatremia, increased pH; anemia; pulmonary edema, heart failure, hypertension. Symptoms of diuretic or recovery phase: urinary output of 4–5 L/day; increased serum BUN; potassium and sodium loss in urine; increased mental and physical activity.

Category: Data Collection/Physiological Integrity/Physiological Adaptation



“My urine often appears pink-tinged.”—seen with urinary tract infections (UTI) or trauma; hematuria not usually a symptom of acute kidney injury

“It is hard for me to start the flow of urine.”—urinary hesitancy seen with UTI, not usually seen with acute kidney injury

“It is quite painful for me to urinate.”—dysuria seen with UTI, not with acute kidney injury

“I urinate in the morning and again before dinner.”—CORRECT: symptoms of acute kidney injury include decreased urinary output (anuria or oliguria), hypotension, tachycardia, lethargy; normal output 1,200–1,500 mL/day or 50–63 mL/hr, normal voiding pattern 5–6 times/day and once at night

88. The Answer is 2

The LPN/LVN is implementing the protocol for teaching a new mother how to breastfeed her newborn. The LPN/LVN knows that teaching has been successful if the client makes which of the following statements?

Reworded Question: What indicates that a newborn is receiving adequate nutrition when breastfeeding?

Strategy: Think about each statement. Is it true?

Needed Info: Breastfeeding is recommended for first 6–12 months of life; human milk is considered ideal food. Colostrum is secreted at first; clear and colorless; contains protective antibodies; high in protein and minerals. Milk is secreted after 2–4 days; milky white appearance; contains more fat and lactose than colostrum.

Category: Evaluation/Health Promotion and Maintenance

“My baby’s weight should equal her birthweight in 5 to 7 days.”—  
breastfeeding infants should surpass birthweight in 10–14 days

“My baby should have at least 6 to 8 wet diapers per day.”—  
CORRECT: indicates newborn adequately hydrated and therefore,  
ingesting adequate nutrition

“My baby will sleep at least 6 hours between feedings.”—newborns  
feed approximately every 2 to 3 hours during the day and every 4  
hours at night

“My baby will feed for about 10 minutes per feeding.”—should feed  
for approximately 15–20 minutes per breast

89. The Answer is 2

A client is admitted to the telemetry unit for evaluation of reported chest pain. Eight hours after admission, the client's cardiac monitor shows ventricular fibrillation. The primary health care provider defibrillates the client. The LPN/LVN understands that the purpose of defibrillation is to do which of the following?

Reworded Question: Why is a client defibrillated?

Strategy: Think about each answer choice.

Needed Info: Defibrillation: delivers an electrical current to the heart that depolarizes myocardial cells. When the cells repolarize, the sino-atrial (SA) node commonly recaptures its role as the heart's pacemaker.

Category: Implementation/Physiological Integrity/Physiological Adaptation

Increase cardiac contractility, preload, and cardiac output—  
inaccurate

Depolarize cells allowing SA node to recapture pacing node—  
CORRECT: electrical current delivered to the heart depolarizes  
myocardial cells allowing the SA node to recapture its pacing role

Reduce the degree of cardiac ischemia and acidosis—inaccurate

Provide electrical energy for depleted myocardial cells—  
inaccurate

90. The Answer is 3

The LPN/LVN is caring for a client who suddenly reports chest pains. The LPN/LVN knows that which of the following symptoms would be most characteristic of an acute myocardial infarction (MI)?

Reworded Question: What type of pain is characteristic in an MI?

Strategy: Think about the cause of each type of pain.

Needed Info: MI signs and symptoms: chest pain radiating to neck, jaw, shoulder, back, or left arm; unrelieved by nitroglycerin. Also fever, apprehension, dizziness, diaphoresis, palpitations, shortness of breath.

Category: Data Collection/Physiological Integrity/Physiological Adaptation

Intermittent, localized epigastric pain—indicates GI disorder

Sharp, localized, unilateral chest pain—symptoms of pneumothorax

Severe substernal pain radiating down the left arm—CORRECT: pain may be crushing; radiate; unrelated to emotion or exercise

Sharp, burning chest pain moving from place to place—may be caused by anxiety

91. The Answer is 1

The primary health care provider prescribes packing for a nonhealing open surgical wound. Which of the following is the first action by the LPN/LVN?

Reworded Question: Which first step is important prior to packing a wound?

Strategy: Determine what you need to know about the wound and dressing. “First action” indicates priority.

Needed Info: Must observe a wound to properly care for the wound and client. Observation allows the nurse to determine what materials are needed, whether another person will be needed to provide assistance, and whether the client will require pain medication prior to the dressing change. Open wounds require sterile technique.

Category: Planning/Safe and Effective Care Environment/Safety and Infection Control

Identify wound size, shape, and depth—CORRECT: it is necessary to observe the wound to adequately prepare for a dressing change

and select appropriate dressing materials

Observe for wound drainage or discharge—this is necessary, but not the first step

Plan to set up for clean technique—an open wound requires sterile, not clean, technique

Select the proper dressing material—this is a safe and expected practice, but not the first step

92. The Answer is 2

A client returns to the clinic 2 weeks after hospital discharge. The client is taking warfarin sodium 2 mg PO daily. Which of the following statements by the client to the LPN/LVN indicates that further teaching is necessary?

Reworded Question: What is contraindicated for warfarin?

Strategy: Think about what each statement means and how it relates to warfarin.

Needed Info: Warfarin sodium: anticoagulant. Side effects: hemorrhage, fever, rash. Prothrombin time (PT) used to monitor effectiveness; PT usually maintained at 1.5–2 times normal. Antidote: vitamin K (aquamephyton). Nursing responsibilities: check for bleeding gums, bruises, nosebleeds, petechiae, melena, tarry stools, hematuria. Use electric razor, soft toothbrush; provide green leafy vegetables (contain vitamin K).

Category: Evaluation/Physiological Integrity/Pharmacological Therapies

“I take an antihistamine before bedtime.”—no contraindication

“I take aspirin whenever I have a headache.”—CORRECT: inhibits platelet aggregation increasing the risk for bleeding; avoid use with warfarin

“I put on sunscreen whenever I go outside.”—correct behavior

“I take an antacid if my stomach gets upset.”—correct information

### 93. The Answer is 3

To enhance the percutaneous absorption of nitroglycerin ointment, it would be most important for the LPN/LVN to select a site that is which of the following?

Reworded Question: What is the best site for nitroglycerin ointment?

Strategy: Think about each site.

Needed Info: Nitroglycerin: used in treatment of angina pectoris to reduce ischemia and relieve pain by decreasing myocardial oxygen consumption; dilates veins and arteries. Side effects: throbbing headache, flushing, hypotension, tachycardia. Nursing responsibilities: teach appropriate administration, storage, expected pain relief, side effects. Ointment applied to skin; sites rotated to avoid skin irritation. Prolonged effect up to 24 hours.

Category: Implementation/Physiological Integrity/Pharmacological Therapies

Muscular—not most important

Near the heart—not most important

Non-hairy—CORRECT: skin site free of hair will increase absorption; avoid distal part of extremities due to less-than-maximal absorption

Bony prominence—most important is that the site be non-hairy since hair interferes with absorption

94. The Answer is 3

When assisting the RN in planning care for a postoperative client, which of the following should be the first choice of the LPN/LVN to reduce the client's risk for pooled airway secretions and decreased chest wall expansion?

Reworded Question: What respiratory intervention is the easiest and most cost-effective to implement?

Strategy: Identify standards of care to prevent respiratory complications for all hospitalized clients.

Needed Info: Causes of respiratory complications in the hospital setting: decreased mobility or immobility of acutely ill clients. To prevent potential complications: frequently reposition clients from side to side, get clients out of bed to a chair, assist clients to ambulate. These actions are cost-effective, easy, and standard practice.

Category: Planning/Physiological Integrity/Basic Care and Comfort

Chest percussion—not necessary for the majority of clients and requires nursing staff or respiratory therapy intervention

Incentive spirometry—not necessary for the majority of clients, adds cost to care and requires a piece of equipment issued to the client

Position changes—CORRECT: can be encouraged and accomplished easily for all clients without any additional expense for equipment or staff

Postural drainage—not necessary for the majority of clients and requires nursing staff or respiratory therapy intervention

95. The Answer is 2

Which of the following actions by the LPN/LVN would be most helpful in preventing injury to elderly clients in a health care facility?

Reworded Question: What is the most frequent cause of injury for the elderly in a health care facility?

Strategy: Think about the primary injury category for the elderly.

Needed Info: Statistically, falls are the most frequent cause of injury for the hospitalized or institutionalized elderly adult. Must protect clients/residents from falls.

Category: Planning/Safe and Effective Care Environment/Safety and Infection Control

Closely monitor the temperature of hot oral fluids—necessary, but not the most frequent cause of injury

Keep unnecessary furniture out of the way—CORRECT: falls are the most common cause of injury, and maintaining an uncluttered



environment can help prevent falls

Maintain the safe function of all electrical equipment—necessary, but not the most frequent cause of injury

Use safety protection caps on all medications—necessary, but bottles of medication should not be accessible to clients

96. The Answer is 4

Which of the following statements by a client during a group therapy session requires immediate follow-up by the LPN/LVN?

Reworded Question: Which statement indicates the possibility of impending danger?

Strategy: Think about which statement would make you question the client's intentions.

Needed Info: In *Tarasoff v. The Regents of the University of California* (1976), the court established a duty to warn of threats of harm to others. Failure to warn, coupled with subsequent injury to the threatened person, exposes the mental health professional to civil damages for malpractice. Based on this and other rulings in many states, the mental health caregiver must take responsibility to warn society of potential danger.

Category: Implementation/Psychosocial Integrity

“I know I’m a chronically compulsive liar, but I can’t help it.”—this statement is revealing, but does not indicate impending threat

“I don’t ever want to go home; I feel safer here.”—this statement is a response to anxiety or fear, but does not indicate immediate danger

“I don’t really care if I ever see my girlfriend again.”—this statement does not imply a threat or impending violence

“I’ll make sure that doctor is sorry for what he said.”—CORRECT: under the Tarasoff Act, a threatened person, including health professionals, must be warned about threats or potential threats to personal safety

97. The Answer is 4

A client newly diagnosed with major neurocognitive disorder (NCD) due to Alzheimer’s disease is admitted to the unit. Which of the following actions by the LPN/LVN is best?

Reworded Question: What is appropriate care for a client with Alzheimer’s disease?

Strategy: Determine whether to collect data or implement.

Needed Info: Alzheimer’s disease: chronic, progressive, degenerative, resulting in cerebral atrophy. S/S: changes in memory, confusion, disorientation, change in personality; most common after age 65.

Nursing responsibilities: reorient as needed; speak slowly; place clocks and calendars in room; place bed in low position with side rails up.

Category: Data Collection/Psychosocial Integrity

Place the client in a semi-private room away from the nurses’ station—should be in a semi-private room near nurses’ station; needs

frequent monitoring

Ask family members to wait in the waiting room during the admission process—familiar people decrease confusion of unfamiliar environment

Assign a different nurse daily to care for the client—consistency is important

Ask the client to state the current date—CORRECT: data collection is the first step in planning care

98. The Answer is 3

A female client visits the clinic reporting right calf tenderness and pain. It would be most important for the LPN/LVN to ask which of the following questions?

Reworded Question: What is a predisposing factor to developing deep vein thrombosis (DVT)?

Strategy: Determine why you would ask each question.

Needed Info: Thrombophlebitis (phlebitis, phlebothrombosis, or DVT): clot formation in a vein secondary to inflammation of vein or partial vein obstruction. Risk factors: history of varicose veins, hypercoagulation, cardiovascular disease, pregnancy, oral contraceptives, immobility, recent surgery, or injury.

Category: Data Collection/Physiological Integrity/Pharmacological Therapies

“Do you exercise excessively?”—excessive exercise could cause shin splints

“Have you had any recent fractures?”—not relevant to client’s reported symptoms

“What type of birth control do you use?”—CORRECT: increased risk of DVT with oral contraceptives

“Are you under a lot of stress?”—should be concerned about possibility of DVT

99. The Answer is 1

Which of the following should be the LPN/LVN’s first priority in providing care for a client who has end-stage ovarian cancer and has been weakened by chemotherapy?

Reworded Question: What is the most important information needed regarding this client?

Strategy: Think about basic needs of every client. Remember Maslow’s hierarchy of needs.

Needed Info: Maslow’s hierarchy of basic human needs: physiological needs must be met before higher-level needs of safety and security, love and belonging, self-esteem, and self-actualization. Untreated pain affects all other physiological needs: oxygenation, food and fluid intake, elimination, ability to rest and sleep, comfort, and activity level.

Category: Planning/Physiological Integrity/Basic Care and Comfort

Collect data to see if client has pain—CORRECT: collecting data to see if the client has pain enables the LPN/LVN to plan for the client's pain management needs

Determine if the client is hungry or thirsty—important physiological needs that are difficult to meet for a client in pain

Explore the client's feelings about dying—important psychological safety and security need that is difficult to meet for a client in pain

Observe the client's self-care abilities—important safety and security need that is difficult to meet for a client in pain

00. The Answer is 2

The LPN/LVN in the postpartum unit is caring for a client who delivered her first child the previous day. The LPN/LVN notes multiple varicosities on the client's lower extremities. Which of the following actions should the LPN/LVN perform?

Reworded Question: What is the best way to prevent thrombophlebitis?

Strategy: Think about what causes thrombophlebitis.

Needed Info: high-risk of developing thrombophlebitis during pregnancy and immediate postpartum period. Thrombophlebitis: inflammation of vein associated with formation of a thrombus or blood clot. Other risk factors: prolonged immobility, use of oral contraceptives, sepsis, smoking, dehydration, and heart failure. S/S: pain in the calf, localized edema of one extremity, positive Homans' sign (pain in calf when foot is dorsiflexed). Treatment: bed rest and elevation of extremity, anticoagulant (heparin).

## Category: Planning/Health Promotion and Maintenance

Teach the client to rest in bed when the baby sleeps—not preventive; bed rest can cause thrombophlebitis

Encourage early and frequent ambulation—CORRECT: facilitates emptying of blood vessels in lower extremities

Apply warm soaks for 20 minutes every 4 hours—not a preventive measure but an intervention used to treat; must be ordered by primary health care provider

Perform passive range-of-motion (ROM) exercises 3 times daily—early ambulation more effective; passive ROM retains joint function, maintains circulation; passive exercises: no assistance from client

### 01. The Answer is 2

The LPN/LVN is caring for a client who sustained a left femur fracture in a bicycle accident. A cast is applied. The nurse knows that which of the following exercises would be most beneficial for this client?

Reworded Question: What exercise is best for a client in a cast?

Strategy: Picture the client as described. Imagine client performing each type of exercise. Also think about the key words “Most beneficial.”

Needed Info: Fracture: break in continuity of bone. Complications: hemorrhage (bone vascular), shock, fat embolism (long bones), sepsis, peripheral nerve damage, delayed union, nonunion. Treatment: reduction (closed or open), immobilization (cast, traction, splints, internal and external fixation). Cast allows early mobility. Nursing responsibilities: teach isometric exercises.

Category: Planning/Physiological Integrity/Reduction of Risk Potential

Passive exercise of the affected limb—nurse moves extremity;  
unable to perform with cast in place

Quadriceps setting of the affected limb—CORRECT: isometric  
exercise: contraction of muscle without movement of joint; maintains  
strength in the affected limb

Active range-of-motion exercises of the unaffected limb—not best,  
doesn't strengthen affected limb

Passive exercise of the upper extremities—need strengthening  
exercises, not passive exercises

02. The Answer is: See Answers and Explanations

In preparation for a dressing change, the LPN/LVN puts on sterile gloves.  
Where should the LPN/LVN initially grip the first sterile glove?



Reworded Question: What is the correct procedure for applying sterile  
gloves?

Strategy: Remember what part of the glove must remain sterile.

Needed Info: Absolutely necessary for the first glove of the pair to be donned in the proper fashion. Grasp the top end of the folded cuff without touching any part of the rest of the sterile glove to avoid contamination from nonsterile hands.

Category: Implementation/Safe and Effective Care Environment/Safety and Infection Control

### 03. The Answer is 2

A client is being discharged from the hospital following a right total hip arthroplasty. The LPN/LVN reinforces discharge teaching. Which of the following statements by the client would indicate that teaching was successful?

Reworded Question: What should a client do after a total hip arthroplasty?

Strategy: Determine which movements bring the right hip toward the median plane of the body (adduction).

Needed Info: Adduction: movement toward the median plane or midline of the body. Adduction precautions implemented to prevent hip dislocation: legs may not be crossed at knees or ankles, knees must be separated (most often with a special pillow). No hip flexion beyond 90 degrees.

Category: Planning/Physiological Integrity/Basic Care and Comfort



“I can bend over to pick up something on the floor.”—this describes flexion, not adduction. It is not allowed for total hip arthroplasty clients

“I should not cross my ankles when sitting in a chair.”—CORRECT: even though the client is only crossing the legs at the ankles, the leg is adducted

“I need to lie on my stomach when sleeping in bed.”—the prone position does not necessarily adduct the hip

“I should spread my knees apart to put on my shoes.”—this movement abducts the hip

#### 04. The Answer is 725

The LPN/LVN is caring for a client with continuous bladder irrigation. At 7 A.M., the LPN/LVN notes 4,200 mL of normal saline solution left in the irrigation bags. During the next shift (7 A.M. to 3 P.M.), the LPN/LVN hangs another 3,000 mL and empties a total of 5,625 mL from the urine drainage bag. At 3 P.M., there are 2,300 mL of irrigant left hanging. What is the actual urine output for the client from 7 A.M. to 3 P.M.?

Reworded Question: After subtracting the irrigant, what is the client’s urinary output?

Strategy: Calculate irrigant used and subtract it from total fluid output to determine urinary output.

Needed Info: Accurate measurement of urinary output is critical. Subtract the irrigant used from the total fluid output to determine the urinary output.

Category: Implementation/Physiological Integrity/Basic Care and Comfort

The irrigant infused was 4,200 mL left at the beginning of the shift + 3,000 mL added – 2,300 mL remaining at the end of the shift = 4,900 mL infused as irrigant. Total output from the catheter bag was 5,625 mL – 4,900 mL of irrigant infused = 725 mL of urine as output.

The correct answer is 725.

05. The Answer is 1

The LPN/LVN is observing activities on a medical/surgical unit. The LPN/LVN should intervene if which of the following is observed?

Reworded Question: What will cause the spread of infection?

Strategy: “Should intervene” indicates an incorrect action.

Needed Info: Standard precautions are used to prevent exposure to blood and body fluids infections; perform hand hygiene as soon as gloves are removed, between client contacts, between procedures or tasks with same client; wear gloves when touching blood, body fluids, or contaminated surfaces; masks, goggles, and gown if splashing is likely.

Category: Evaluation/Safe and Effective Care Environment/Safety and Infection Control

A client’s family member disposes of the client’s used tissue in the bedside container before opening the roommate’s milk carton—

CORRECT: contaminated hands cause cross-contamination; instruct family about hand hygiene

An UAP removes gloves and washes hands for 15 seconds after emptying an indwelling urinary catheter—perform hand hygiene after removing gloves

An LPN/LVN puts on a gown, gloves, mask, and goggles prior to inserting a nasogastric tube—appropriate technique; splashes may occur

A visitor talks with a client diagnosed with methicillin-resistant *Staphylococcus aureus* (MRSA) wound infection while eating lunch—client in isolation may develop sense of loneliness; visiting with client during meals increases sensory stimulation

06. The Answer is 3

A client with a history of type 1 diabetes mellitus is admitted to the unit reporting nausea, vomiting, and abdominal pain. The client reduced the insulin dose four days ago when influenza symptoms prevented eating. The LPN/LVN observes poor skin turgor, dry mucous membranes, and fruity breath odor. The LPN/LVN should be alert for which of the following problems?

Reworded Question: What do these symptoms indicate?

Strategy: Think about each answer choice.

Needed Info: Diabetes mellitus: disorder of carbohydrate metabolism: insufficient insulin to meet metabolic needs. Type 1 diabetes mellitus: insulin dependent, prone to diabetic ketoacidosis. Type 2 diabetes mellitus: controlled by diet and oral antidiabetic agents, not prone to

ketosis. In ketoacidosis, the body becomes dehydrated from osmotic diuresis. The fruity breath odor develops from acetone, a component of ketone bodies. Rate and depth of respiration increase (Kussmaul) in attempt to blow off excess carbonic acid. Hyperosmolar nonketonic syndrome (HHNS)—lacks ketonuria.

Category: Planning/Physiological Integrity/Reduction of Risk Potential

Rebound hypoglycemia—cause: too much insulin after a period of hyperglycemia; blood glucose level falls below 60 mg/dL (3.3 mmol/L); S/S: tachycardia, perspiration, confusion, lethargy, numb lips, anxiety, hunger

Viral gastrointestinal illness—may produce similar symptoms, not best answer based on client history

Diabetic ketoacidosis—CORRECT: cause: insufficient insulin; S/S: polyuria, polydipsia, nausea, vomiting, dry mucous membranes, weight loss, abdominal pain, hypotension, shock, coma

Hyperglycemic hyperosmolar nonketotic syndrome— extreme hyperglycemia (800–2,000 mg/dL [44.4–111 mmol/L]) with absence of acidosis; some insulin production, don't mobilize fats for energy or form ketones; usually with type 2 diabetes; cause: infections, stress, medications (steroids, thiazide diuretics), total parenteral nutrition; S/S: polyphagia, polyuria, polydipsia, glycosuria, dehydration, abdominal discomfort, hyperpyrexia, changes in level of consciousness (LOC), hypotension, shock; treatment: fluid and electrolyte replacement, insulin given IV

The LPN/LVN is caring for a group of clients. The nurse knows that it is most important for which of the following clients to receive scheduled medications on time?

Reworded Question: Which medication, if given late, might cause harm to the client?

Strategy: Think about each answer.

Needed Info: Myasthenia gravis is deficiency of acetylcholine at myoneural junction; symptoms include muscular weakness produced by repeated movements that soon disappears following rest, diplopia, ptosis, impaired speech, and dysphagia.

Category: Planning/Physiological Integrity/Pharmacological Therapies

A client diagnosed with myasthenia gravis receiving pyridostigmine bromide—CORRECT: Pyridostigmine bromide is a cholinesterase inhibitor, which increases acetylcholine concentration at the neuromuscular junction; early administration can precipitate a cholinergic crisis; late administration can precipitate myasthenic crisis

A client diagnosed with bipolar disorder receiving lithium carbonate—Lithium carbonate is a mood stabilizer; targeted blood level = 1–1.5 mEq/L (1–1.5 mmol/L)

A client diagnosed with tuberculosis receiving isonicotinic acid hydrazide—Isonicotinic acid hydrazide (INH) is given in a single daily dose; side effects include hepatitis, peripheral neuritis, rash, and fever

A client diagnosed with Parkinson's disease receiving levodopa—Levodopa is thought to restore dopamine levels in extrapyramidal centers; sudden withdrawal can cause parkinsonian crisis; priority is to administer pyrostigmine bromide

08. The Answer is 3

An school-age client is admitted to the hospital for evaluation for a kidney transplant. The LPN/LVN learns that the client received hemodialysis for 3 years due to stage 5 kidney disease. The LPN/LVN knows that the illness can interfere with this client's achievement of which of the following?

Reworded Question: What developmental stage is altered in a client due to this chronic disease?

Strategy: Picture the person described in the question. Think about his activities and interests. This helps eliminate incorrect answer choices. A school-age client may be thinking about homework, or doing chores at home.

Needed Info: Eric Erikson developed a theory of the stages of personality development that progressed in predictable stages from birth to death. Other stages: autonomy versus shame and doubt (task of 1–3 yrs); initiative versus guilt (task of 3–6 yrs).

Category: Planning/Health Promotion and Maintenance

Intimacy—young adult: 20–40 yrs; achieving sexual and loving relationship with another; alternative: isolation

Trust—infancy; results from consistent care by a loving caretaker; teaches that basic needs will be met; alternative: mistrust

Industry—CORRECT: 6–12 yrs; aspires to be the best; learns social skills, how to finish tasks; sensitive about school expectations; may be impaired due to absences from school, growth retardation, and emotional difficulties

Identity—adolescence; peer groups important; used to define identity, establish body image, form new relationships; alternative: role diffusion

09. The Answer is 2, 3, 5, and 6

The LPN/LVN notes that a client has an unsteady gait. The LPN/LVN should do which of the following? Select all that apply.

Reworded Question: What safety measures are appropriate for a client who is unsteady on his or her feet?

Strategy: Identify nonrestrictive safety measures.

Needed Info: Safety measures to help prevent falls include: rubber-soled (nonskid) shoes, removal of obstacles and clutter, a method of summoning the help of the nursing staff, assistance when out of bed, adequate lighting, safety bars and hand rails, and adaptive equipment including walkers and raised toilet seats as appropriate.

Category: Implementation/Safe and Effective Care Environment/Safety and Infection Control

Apply a chest or vest restraint at night—restrictive and false imprisonment without a primary health care provider's orders

Help the client put on nonskid shoes for walking—CORRECT: a choice that decreases fall risk without restricting the client

Keep the call light within the client's reach—CORRECT: not restrictive and addresses the client's need to call for assistance when getting out of bed

Lower the bed and raise all four side rails—lowering the bed is appropriate, but raising all the side rails only increases the height from which a client may fall while climbing over the side rails

Provide adequate lighting in room and bathroom—CORRECT: allows client to assess an unfamiliar hospital environment

Remove obstacles and room clutter—CORRECT: provides clear access to room and bathroom

#### 10. The Answer is 2

Haloperidol 5 mg PO tid is prescribed for a client with schizophrenia. Two days later, the client reports “tight jaws and a stiff neck.” The LPN/LVN should recognize that these complaints are which of the following?

Reworded Question: Why does the client taking haloperidol have these symptoms?

Strategy: Think about each answer choice.

Needed Info: Haloperidol, antipsychotic agent used to treat psychotic disorders. High incidence of extrapyramidal reactions: pseudoparkinsonism (rigidity and tremors), akathisia (motor



restlessness), dystonia (involuntary jerking, of muscles, acute muscular rigidity and cramping), tardive dyskinesia (abnormal movements of lips, jaws, tongue). Schizophrenia: retreat from reality, flat affect, suspiciousness, hallucinations, delusions, loose associations, psychomotor retardation or hyperactivity, regression. Nursing responsibilities: maintain safety, meet physical needs, decrease sensory stimuli. Treatment: antipsychotic medications, individual therapy.

Category: Evaluation/Physiological Integrity/Pharmacological Therapies

Common side effects of antipsychotic medications that will diminish over time—gets worse, untreated, life-threatening

Early symptoms of extrapyramidal reactions to the medication—  
CORRECT: dystonic reaction, airway may become obstructed

Psychosomatic symptoms resulting from a delusional system—not accurate

Permanent side effects associated with haloperidol therapy—  
reversible when treated with IV diphenhydramine hydrochloride

#### 11. The Answer is 4

A client is receiving a continuous gastric tube feeding at 100 mL per hour. The LPN/LVN checks for gastric residual volume and finds 90 mL in the client's stomach. Which action should the LPN/LVN take?

Reworded Question: What are the standards and procedures for gastric residual volume from a gastric tube feeding?

Strategy: Think about electrolyte balance and gastric emptying.

Needed Info: Standard procedures for clients receiving continuous tube feedings: gastric residual volume and tube placement checked every 4 hours, position clients with head of bed elevated at least 30 degrees. To promote normal function: gastric residual volume with associated gastric enzymes and hydrochloric acid should be returned to the stomach when gastric residual volume measures under 150 mL, feeding should be stopped if the gastric residual volume is over 50% of the volume fed over the last 1 hour.

Category: Physiological Integrity/Basic Care and Comfort/Analysis

Discard the gastric residual volume and continue the tube feeding—gastric residual volume under 150 mL should be returned to the stomach to maintain electrolyte balance; the feeding should be stopped because the gastric residual volume exceeds 50% of the volume fed over 1 hour

Discard the gastric residual volume and stop the tube feeding—return the gastric residual volume and stop the feeding

Return the gastric residual volume and continue the tube feeding—return the gastric residual volume and stop the feeding

Return the gastric residual volume and stop the tube feeding—CORRECT: residuals less than 150 mL should be returned to the stomach to maintain electrolyte balance; the feeding should be stopped because the gastric residual volume exceeds 50% of the volume fed over 1 hour

12. The Answer is 4

The LPN/LVN opens several sterile gauze dressings on the client's over-the-bed table. The LPN/LVN knows that the sterile dressings will be

contaminated if she does which of the following?

Reworded Question: What is incorrect sterile technique?

Strategy: List the basic principles of sterile technique.

Needed Info: To maintain sterility of sterile objects: may only touch other sterile objects, must remain in the LPN/LVN's view, must be above the LPN/LVN's waist, cannot be exposed to air for prolonged periods, must be located inside the 1-inch (2.5 cm) border of a sterile field or within the dressing packaging borders, sterile fluids must not contact a nonsterile object when fluids flow with gravity. The client's over-the-bed table is not sterile.

Category: Evaluation/Safe and Effective Care Environment/Safety and Infection Control

Does not allow the dressings prolonged exposure to the air—a principle of sterile technique

Keeps sterile dressings inside border of the sterile packaging—a principle of sterile technique

Positions top of the over-the-bed table at or above waist level—a principle of sterile technique

Pours sterile saline onto the opened sterile dressing on table —  
CORRECT: capillary action and gravity lead to contamination of the sterile object because of contact between the nonsterile over-the-bed table and the once-sterile fluid

13. The Answer is 3

A client has adamantly refused hygiene measures over the past 3 days. Eventually the LPN/LVN was able to collaborate with the client to develop the hygiene goal: “self-administration of a complete bath daily while in the hospital.” To evaluate if this goal is achieved, the LPN/LVN should do which of the following?

Reworded Question: What is the most objective method to evaluate goal attainment of a psychomotor skill?

Strategy: Identify how you can best objectively determine if the client did bathe.

Needed Info: Goals and expected outcomes of nursing process provide the focus for the effectiveness of the planned nursing interventions. To validate that a goal has been met, measurable criteria are needed.

Category: Evaluation/Physiological Integrity/Basic Care and Comfort

Ask the client whether self-bathing was accomplished—asking the client about bathing is not measurable and may not always be reliable

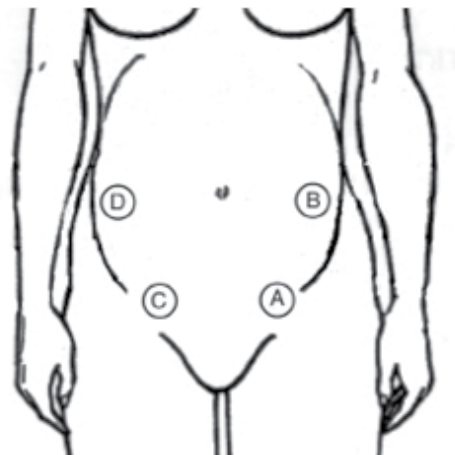
Bathe the client to be sure the hygiene goal is met—this does not support the goal of a self-administered bath

Observe the client performing portions of the daily bath—  
CORRECT: direct observation provides the LPN/LVN with objective measurable data that the client has met the goal

Remind the client to bathe and provide the needed supplies—  
places all the responsibility on the client and does not actively create client compliance

14. The Answer is 1

The LPN/LVN is caring for a client in labor. The primary health care provider palpates a firm, round form in the uterine fundus, small parts on the client's right side, and a long, smooth, curved section on the left side. Based on these findings, where should the LPN/LVN anticipate auscultating the fetal heart tones?



Reworded Question: If a fetus is LOA, where should the nurse listen for the fetal heart tone?

Strategy: Examine the diagram carefully. Know the woman's right from left.

Needed Info: Fetal reference point: Vertex presentation—dependent upon degree of flexion of fetal head on chest; full flexion/occiput (O), full extension chin (M), moderate extension (military) brow (B). Breech presentation-sacrum (S). Shoulder presentation-scapula (SC). Maternal pelvis is designated per her right/left and anterior/posterior. Position = relationship of fetal reference point to mother's pelvis; expressed as standard 3—letter abbreviation: left occiput anterior (LOA) (most

common), left occiput posterior (LOP), right occiput anterior (ROA), right occiput posterior (ROP), left occiput transverse (LOT), right occiput transverse (ROT).

Category: Planning/Health Promotion and Maintenance

- A—CORRECT: point of maximum intensity for fetal heart tones with fetus in LOA position
- B—PMI location for fetus in LOP position
- C—PMI location for fetus in ROA position
- D—PMI location for fetus in ROP position

15. The Answer is 4

When completing data collection of an immobilized client, the LPN/LVN knows that edema is commonly observed in which of the following locations?

Reworded Question: Where does dependent edema occur in an immobile client? What position is the immobilized client usually in?

Strategy: Identify where dependent edema is likely to settle due to gravity in a client supine.

Needed Info: Immobile clients: most often horizontal in bed, gravity would cause fluid pooling at the most dependent place, namely, the sacrum. Mobile clients: fluids pool in dependent areas such as their feet and ankles.

Category: Data Collection/Physiological Integrity/Basic Care and Comfort

Abdomen—not a likely place for dependent edema

Feet and ankles—a primary place for edema in a client who is sitting up or out of bed walking

Fingers and wrists—not a likely place to initially find dependent edema

Sacrum—CORRECT: gravity causes dependent edema to develop at the sacrum in immobile clients

16. The Answer is 1

A client is preparing to take her 1-day-old infant home from the hospital. The LPN/LVN discusses the test for phenylketonuria (PKU) with the client. The LPN/LVN's reinforcement of teaching should be based on an understanding that the test is most reliable in which of the following circumstances?

Reworded Question: When is the PKU test most reliable?

Strategy: Focus on the key words in the question. Think about what you know about the PKU test.

Needed Info: PKU: genetic disorder caused by a deficiency in liver enzyme phenylalanine hydroxylase. Body can't metabolize essential amino acid phenylalanine, allows phenyl acids to accumulate in the blood. If not recognized, resultant high levels of phenyl ketone in the brain cause intellectual disability. Guthrie test: screening for PKU. Treatment: dietary restriction of foods containing phenylalanine. Blood

levels of phenylalanine monitored to evaluate the effectiveness of the dietary restrictions.

Category: Implementation/Health Promotion and Maintenance

After a source of protein has been ingested—CORRECT:  
recommended to be performed before newborns leave hospital; if initial blood sample is obtained within first 24 hours, recommended to be repeated at 3 weeks

After the meconium has been excreted—no relationship; dark-green, tarry stool passed within first 48 hours of birth

After the danger of hyperbilirubinemia has passed—no relationship; excessive accumulation of bilirubin in blood; S/S: jaundice (yellow discoloration of skin); common finding in newborn; not cause for concern

After the effects of delivery have subsided—no relationship

17. The Answer is 3

The LPN/LVN is caring for an Rh-negative client who has delivered an Rh-positive child. The client states, “The doctor told me about RhoGAM, but I’m still a little confused.” Which of the following responses by the LPN/LVN is most appropriate?

Reworded Question: What is RhoGAM and why is it used?

Strategy: Remember what you know about RhoGAM.

Needed Info: RhoGAM: given to unsensitized Rh-negative (RH-) mother after delivery or abortion of an Rh-positive (Rh<sup>+</sup>) infant or fetus to



prevent development of sensitization. Rh<sup>-</sup> mother produces antibodies in response to the Rh<sup>+</sup> RBCs of fetus. If occurs during pregnancy, fetus is affected. If occurs during delivery, later pregnancies may be affected. An indirect Coombs' test is performed on the mother during pregnancy, and a direct Coombs' test is done on cord blood after delivery. If both are negative and the neonate is Rh<sup>+</sup>, the mother is given RhoGAM to prevent sensitization. RhoGAM is usually given to unsensitized mothers within 72 hrs of delivery, but may be effective when given 3–4 weeks after delivery. To be effective, RhoGAM must be given after the first delivery and repeated after each subsequent delivery. RhoGAM is ineffective against Rh<sup>+</sup> antibodies that are already present in the maternal circulation. The administration of RhoGAM at 26–28 weeks' gestation is also recommended.

Category: Implementation/Health Promotion and Maintenance

“RhoGAM is given to your child to prevent the development of antibodies.”—not given to neonate

“RhoGAM is given to your child to supply the necessary antibodies.”—not given to neonate

“RhoGAM is given to you to prevent the formation of antibodies.”—  
CORRECT: prevents maternal circulation from developing antibodies

“RhoGAM is given to you to encourage the production of antibodies.”—not accurate; given to discourage antibody production

18. The Answer is 2

A woman is hospitalized with a diagnosis of bipolar disorder. While she is in the client activities room on the psychiatric unit, she flirts with male

clients and disrupts unit activities. Which of the following approaches would be most appropriate for the LPN/LVN to take at this time?

Reworded Question: How should you deal with a client with bipolar disorder who is disruptive?

Strategy: Determine the outcome of each answer. Is it desirable?

Needed Info: Nursing responsibilities: accompany client to room when hyperactivity escalates, set limits, remain nonjudgmental.

Category: Planning/Psychosocial Integrity

- Set limits on the behavior and remind the client of the rules—too confrontational

- Distract the client and escort the client back to the room—  
CORRECT: clients are easily distracted; nonthreatening action

- Instruct the other clients to ignore this client's behavior—does not ensure safety

- Inform client of negative behavior and return client to room—too confrontational; may agitate

#### 19. The Answer is 1

A client is brought to the emergency department bleeding profusely from a stab wound in the left chest area. Vital signs include: blood pressure 80/50 mm Hg, pulse 110 beats/minute, and respiratory rate 28 breaths/minute. The LPN/LVN should expect which of the following potential problems?

Reworded Question: What type of shock is described?

Strategy: Form a mental image of the person described.

Needed Info: Symptoms of hypovolemic shock: tachycardia, reduced output, irritability. Treatment: oxygen therapy, IV fluids to restore volume, adrenaline, hydralazine. Nursing responsibilities: check airway, vital signs, insert IV catheter, check arterial blood gas results, central venous pressure measurements, insert indwelling urinary catheter, hourly intake and output, position flat with legs elevated, keep warm.

Category: Planning/Physiological Integrity/Physiological Adaptation

Hypovolemic shock—CORRECT: loss of circulating volume

Cardiogenic shock—decrease in cardiac output; causes include heart failure, MI, cardiac dysfunction

Neurogenic shock—increase in vascular bed; caused by spinal anesthesia, spinal cord injury

Septic shock—decreased cardiac output, hypotension; may be caused by gram-negative or gram-positive bacteria

20. The Answer is 3

A client is admitted to the hospital for surgical repair of a detached retina in the right eye. In implementing the plan of care for this client postoperatively, the LPN/LVN should encourage the client to do which of the following?

Reworded Question: What should you do after surgery for a detached retina?

Strategy: Picture the client as described.

Needed Info: Detached retina: separation of retina from pigmented epithelium. S/S: curtain falling across field of vision, black spots, flashes of light, sudden onset. Treatment: surgical repair (photocoagulation, electrodiathermy, cryosurgery, scleral buckling). Complications: infection, redetachment, increased intraocular pressure. Nursing responsibilities postoperatively: check eye patch for drainage, position with detached area dependent; no rapid eye movement (reading, sewing); no coughing, vomiting, sneezing.

Category: Planning/Physiological Integrity/Reduction of Risk Potential

- Perform self-care activities—activity restrictions depend on location and size of tear

- Maintain patches over both eyes—only affected eye covered

- Limit movement of both eyes—CORRECT: bed rest with eye patch or shield

- Refrain from excessive talking—no restriction

21. The Answer is 2

The LPN/LVN is caring for a client who receives a balanced complete formula through an enteral feeding tube. The LPN/LVN knows that the most common complication of an enteral tube feeding is which of the following?

Reworded Question: What is a common complication of a tube feeding?

Strategy: Think about each answer choice. Focus on the words “Most common,” which means there may be more than one answer. And in this situation there is: #4 is a complication but is not common.

Needed Info: Enteral tube feedings are used for clients who are unable to tolerate feeding by the oral route but who have a functioning GI tract. May be given by intermittent or continuous infusion. Elevate head of bed 30–45 degrees. Give at room temperature. Check for placement before feeding. Don’t hang solution for more than 6 hrs. Flush tubing with 30 mL water every 4 hrs. Change feeding set every 24 hrs. Balanced complete formula contains intact protein.

Category: Evaluation/Physiological Integrity/Basic Care and Comfort

Edema—not frequently seen; if present primary health care provider may change formula to a low-sodium

Diarrhea—CORRECT: formula intolerance or rate intolerance; give slowly; other symptoms of intolerance: nausea, vomiting, aspiration, glycosuria, diaphoresis

Hypokalemia—normal potassium 3.5–5 mEq/L (3.5–5 mmol/L); not commonly seen; common causes: diuretics, diarrhea, GI drainage

Vomiting—can happen with rapid increase in rate; administer slowly

## 22. The Answer is 4

An infant is brought to the hospital for treatment of pyloric stenosis. The following nursing diagnosis is on the infant’s care plan: “fluid volume deficit related to vomiting.” The LPN/LVN would expect to see which of the following findings to support this diagnosis?

Reworded Question: What would indicate volume deficit?

Strategy: How does each answer relate to fluid volume deficit?

Needed Info: Pyloric stenosis: obstruction of the sphincter between stomach and duodenum. Onset: within 2 months of birth. S/S: vomiting that becomes projectile. Treatment: surgery. Nursing responsibilities: small frequent feedings with glucose water or electrolyte solutions 4–6 hrs postoperatively. Small frequent feedings with formula 24 hrs postoperatively.

Category: Data Collection/Physiological Integrity/Physiological Adaptation

The infant eagerly accepts feedings—may vomit after eating

The infant vomited once since admission—don't assume will continue to vomit

The infant's skin is warm and moist—normal; would be cool and dry with fluid volume deficit

The infant's anterior fontanel is depressed—CORRECT: indicates dehydration

23. The Answer is 1

The LPN/LVN is caring for a preschool-age client diagnosed with a fractured pelvis caused by a motor vehicle accident. The LPN/LVN prepares the child for the application of a hip spica cast. It is most important for the LPN/LVN to take which of the following actions?

Reworded Question: How do you prepare a preschool-age client for the procedure?

Strategy: “Most important” indicates that discrimination is required to answer the question.

Needed Info: Hip spica cast immobilizes the hip and knee. Preschool children (age 36 months to 6 years) fear injury, mutilation, and punishment; allow child to play with models of equipment; encourage expression of feelings.

Category: Planning/Health Promotion and Maintenance

Obtain a doll for the client with a hip spica cast in place—  
CORRECT: preschoolers need to see and play with dolls and equipment; explain procedure in simple terms and explain how it will affect the client

Tell the client that the cast will feel cold when applied—may feel a warm or burning sensation under cast while it dries due to chemical reaction between the plaster and the water

Reassure the client that the cast application is painless—will be placed on special cast table that holds the client’s body; turning to apply the cast may be painful

Introduce the client to another client who has a hip spica cast—  
more important to allow client to play with doll with a hip spica cast; viewing the cast may be frightening

A client comes to the clinic because for suspected pregnancy. Tests confirm pregnancy. The client's last menstrual period began on September 8 and lasted for 6 days. The LPN/LVN calculates that her expected date of confinement (EDC) is which of the following?

Reworded Question: How do you calculate the EDC?

Strategy: Perform the calculation required and check for math errors!

Needed Info: EDC or estimated date of delivery (EDD): calculated according to Nägele's rule (first day of the last normal menstrual period minus 3 months plus 7 days and 1 year). Assumes that every woman has a 28-day cycle and pregnancy occurred on 14th day. Most women deliver within a period extending from 7 days before to 7 days after the EDC.

Category: Implementation/Health Promotion and Maintenance

May 15—too early

June 15—CORRECT September 8 minus 3 months = June 8 plus 7 days plus one year = June 15 of next year

June 21—EDC is calculated from first, not last day, of last normal menstrual period

July 8—not accurate

25. The Answer is 3

An infant is brought to the pediatrician's office for a well-baby visit. During the examination, congenital subluxation of the left hip is



suspected. The LPN/LVN would expect to see which of the following symptoms?

Reworded Question: What will you see with congenital hip dislocation?

Strategy: Form a mental image of the deformity.

Needed Info: Subluxation: most common type of congenital hip dislocation. Head of femur remains in contact with acetabulum but is partially displaced. Diagnosed in infant less than 4 weeks old S/S: unlevel gluteal folds, limited abduction of hip, shortened femur affected side, Ortolani's sign (click). Treatment: abduction splint, hip spica cast, Bryant's traction, open reduction.

Category: Data Collection/Health Promotion and Maintenance

Lengthening of the limb on the affected side—inaccurate

Deformities of the foot and ankle—inaccurate

Asymmetry of the gluteal and thigh folds—CORRECT: restricted movement on affected side

Plantarflexion of the foot—seen with clubfoot

26. The Answer is 4

After completing data collection, the LPN/LVN observes that a client is exhibiting early symptoms of a dystonic reaction related to the use of an antipsychotic medication. Which of the following actions by the LPN/LVN would be most appropriate?

Reworded Question: What is the first thing you do for a client with a dystonic reaction?

Strategy: Set priorities. Remember Maslow's hierarchy of needs.

Needed Info: Dystonic reaction: muscle tightness in throat, neck, tongue, mouth, eyes, neck, and back; difficulty talking and swallowing.  
Treatment: IM or IV diphenhydramine or benztropine.

Category: Implementation/Psychosocial Integrity

- Reality-test with the client and assure the client that physical symptoms are not real—real symptoms, not delusions

- Teach the client about common side effects of antipsychotic medications—physical needs highest priority

- Explain to the client that there is no treatment that will relieve these symptoms—diphenhydramine used IM or IV

- Notify the primary health care provider to obtain a prescription for IM diphenhydramine—CORRECT: emergency situation, can occlude airway

27. The Answer is 1

The LPN/LVN is preparing to perform mouth care for an unconscious client. Which of the following actions should the LPN/LVN take first?

Reworded Question: Before initiating any care or procedure, what should the LPN/LVN do first to provide for client safety?

Strategy: Think ABCs when identifying first nursing action.

Needed Info: An unconscious client cannot protect himself from injury. Consider the ABCs. Sims' position: lying on left side with right knee and thigh drawn up to the chest. Gag reflex: prevents aspiration of secretions and food, fluid, and objects.

Category: Data Collection/Physiological Integrity/Basic Care and Comfort

Assess for the presence of a gag reflex—CORRECT: the LPN/LVN is responsible for determining if the client can clear own airway or is at risk for occlusion or aspiration

Place the client into Sims' position—an accurate position for mouth care for this client, but not the initial step

Separate teeth with a padded tongue blade—nothing should be used to separate the teeth; would likely lead to tooth damage

Suction secretions from the oral cavity—an accurate procedural step that should occur after the client's gag reflex is determined

28. The Answer is 1

As a client nears death, the client's husband says, "I wish I could do something for her." Which of the following responses by the LPN/LVN is most appropriate?

Reworded Question: What is the most therapeutic communication for the husband?

Strategy: Think about the husband's need to help his wife.

Needed Info: End-of-life research: last of the senses of a dying person is believed to be hearing, reports of survivors support the reassurance they felt from the words of the caregivers present. Therapeutic communication: supports inclusion of significant others, supports “hope” or “usefulness” on the part of significant others.

Category: Evaluation/Psychosocial Integrity

“It may be comforting if you talk to her calmly and clearly.”—  
CORRECT: the client may actually hear her family member's communications; the family member is offered something to do that may be helpful to both the client and the family member

“She does not know that you are here, but you can sit here.”—the client may be aware that her family member is there, and it is nontherapeutic to exclude the family member from offering comfort

“Unfortunately, there is little that you can do at this point.”—it is nontherapeutic to exclude the family member from offering comfort

“Why don’t you take a break? It is just a matter of time now.”—it is nontherapeutic to exclude the family member from offering comfort

29. The Answer is 4

The LPN/LVN is providing care to clients in a long-term care facility. Four meal choices are available to the clients. The LPN/LVN should ensure that a client on a low-cholesterol diet receives which of the following meals?

Reworded Question: What should a client on a low-cholesterol diet eat?

Strategy: Remember which foods are part of a low-cholesterol diet.

Needed Info: Low-cholesterol diet should reduce total fat to 20–25% of total calories and reduce the ingestion of saturated fat. Carbohydrates (especially complex carbohydrates) should be 55–60% of calories. High-cholesterol foods: eggs, dairy products, meat, fish, shellfish, poultry.

Category: Implementation/Physiological Integrity/Basic Care and Comfort

Egg custard and boiled liver—high amounts of cholesterol

Fried chicken and potatoes—avoid fried foods

Hamburger and french fries—avoid fried foods

Grilled flounder and green beans—CORRECT: fish instead of meat; increase vegetables

30. The Answer is 465

The LPN/LVN is removing a client's breakfast tray and notes that the client consumed 4 oz of pudding, 4 oz of gelatin, 6 1/2 oz of tea, and 5 oz of apple juice. How many milliliters should the LPN/LVN record for the client's breakfast intake?

Reworded Question: Calculate the client's oral fluid intake in mL.

Strategy: Remember what is considered oral fluid intake.

Needed Info: Oral fluid intake: any liquid or food in more solid form that melts at room temperature.

Category: Data Collection/Physiological Integrity/Basic Care and Comfort

The calculation is 4 oz gelatin + 6½ oz of tea + 5 oz of apple juice = 15½ oz × 30 mL = 465 mL. Pudding does not melt at room temperature, so is not considered to be a liquid and therefore it is not included in the calculation.

The correct answer is 465.

31. The Answer is 2

The LPN/LVN is caring for a client diagnosed with cholecystitis. The client says to the LPN/LVN, “I don’t understand why my right shoulder hurts when the gallbladder is not by my shoulder!” Which of the following responses by the LPN/LVN is best?

Reworded Question: Why does the client’s shoulder hurt?

Strategy: “Best” indicates discrimination is required to answer the question.

Needed Info: Cholecystitis is inflammation of the gallbladder; indications include intolerance to fatty foods, indigestion, severe pain in right upper quadrant of abdomen radiating to back and right shoulder; leukocytosis, and diaphoresis.

Category: Implementation/Physiological Integrity/Physiological Adaptation

“Sometimes small pieces of the gallstones break off and travel to other parts of the body.”—gallstones do not become emboli

“There is an invisible connection between the gallbladder and the right shoulder.”—CORRECT: describes referred pain; when visceral branch of a pain receptor fiber is stimulated, vasodilation and pain may occur in a distant body area; right shoulder or scapula is the referred pain site for gallbladder

“The gallbladder is on the right side of the body and so is that shoulder.”—anatomically correct but is not the best explanation

“Your shoulder became tense because you were guarding against the gallbladder pain.”—possible; not the best explanation

### 32. The Answer is 4

A woman comes to the clinic at 32 weeks' gestation. A diagnosis of pregnancy-induced hypertension (PIH) is made. The LPN/LVN is reinforcing teaching performed by the RN. Which of the following statements by the client indicates that further teaching is required?

Reworded Question: What is not accurate about the care of a woman with PIH?

Strategy: This is a negative question. Look for incorrect information.

Needed Info: PIH, preeclampsia, toxemia: development of hypertension (increase 30 mmHg systolic or 15 mmHg diastolic) with proteinuria and/or edema (dependent or facial) after 20 weeks' gestation. Risk factors: parity (first-time mothers), age (younger than 20 or older than 35), geographic location (southern or western United States), multifetal gestation, hydatidiform mole, hypertension, and diabetes. Prevention: early prenatal care, identify high-risk clients, recognize S/S early; bed rest lying on L side, daily weights. Treatment: urine checks for

proteinuria; diet (increased protein and decreased  $\text{Na}^+$ ). Can develop into eclampsia (convulsions or coma).

Category: Evaluation/Health Promotion and Maintenance

“Lying in bed on my left side is likely to increase my urinary output.”—true; bed rest promotes good perfusion of blood to uterus; decreases blood pressure and promotes diuresis

“If the bed rest works, I may lose a pound or two in the next few days.”—true; causes diuresis; results in reduction of retained fluids; instruct to monitor weight daily and notify primary health care provider if notices abrupt increase even after resting in bed for 12 hours

“I should be sure to maintain a diet that has a good amount of protein.”—true; replaces protein lost in urine; increases plasma colloid osmotic pressure; avoid salty foods; avoid alcohol; drink 8 glasses of water daily; eat foods high in roughage

“I will have to keep my room darkened and not watch much television.”—CORRECT: incorrect info, not necessary; diversional activities helpful

33. The Answer is 4

The LPN/LVN is collecting data about a client’s fluid balance. Which of the following findings most accurately indicates to the LPN/LVN that the client has retained fluid during the previous 24 hours?

Reworded Question: How can the LPN/LVN most accurately determine fluid retention?



Strategy: Look at the most conclusive means of determining fluid retention.

Needed Info: Means of evaluating fluid retention: recording fluid intake and output; determining areas of edema especially the sacrum, feet, and ankles; listening for wet lung sounds; and measuring short-term weight gain. Weight gain: most objective and accurate. Weight gain of 2.2 lb (1 kg) is equivalent to 1 L of fluid.

Category: Data Collection/Physiological Integrity/Basic Care and Comfort

Edema is found in both ankles—unable to consistently quantify this form of data

Fluid intake is equal to fluid output—this is normal but does not account for insensible fluid loss through the skin and lungs

Intake of fluid exceeds output by 200 mL—provides information, but does not eliminate the possibility of error recording all intake and output

Weight gain of 4 lb (1.8 kg) is noted—CORRECT: identifies fluid retention in a factual, accurate method and is unlikely to represent a gain of actual body substance (muscle or fat) in a 24-hour time frame

34. The Answer is 4

The LPN/LVN is caring for a group of residents in a dependent-living facility. The LPN/LVN determines which of the following clients is most at risk to develop pneumonia?

Reworded Question: Who is most likely to develop pneumonia?

Strategy: Think about each answer.

Needed Info: Pneumonia is an inflammatory process that results in edema of lung tissues and extravasion of fluid into alveoli, causing hypoxia; symptoms include fever, leukocytosis, productive cough, dyspnea, and pleuritic pain.

Category: Evaluation/Health Promotion and Maintenance

A client female with left-sided hemiparesis after a stroke—stroke is a risk factor

A client who has a history of hypertension and type 2 diabetes—diabetes is a risk factor

A client with a history of depression who walks one mile daily—no risk factors

A client who smokes and has a history of lung cancer—CORRECT: smoking, underlying lung disease, malnutrition, and bedridden status are risk factors for development of pneumonia

35. The Answer is 2

The LPN/LVN is caring for a client diagnosed with bipolar disorder. Which of the following behaviors by the client indicates that a manic episode is subsiding?

Reworded Question: What indicates normalizing behavior?

Strategy: Think about the behaviors that indicate mania.

Needed Info: Manic clients may tease, talk, and joke excessively, usually cannot sit to eat and may need to carry fluids and food around in order to eat, often try to take a leadership position in an environment, and try to engage others.

Category: Data Collection/Psychosocial Integrity

The client tells several jokes during a group meeting—reflects an elated mood and no real participation in the meeting; manic clients may tease, talk, and joke excessively

The client sits and talks with other clients at mealtimes—  
CORRECT: manic clients have difficulty socializing because of flight of ideas and intrusiveness; usually cannot sit to eat and will carry fluids and food around

The client begins to write a book about personal story—manic clients often write voluminously; may help to express feelings, but does not reflect improvement, especially if thoughts are grandiose

The client initiates a unit effort to start a radio station—manic clients often try to take a leadership position in an environment and try to recruit others

36. The Answer is 2

A parent brings a child to the pediatrician for treatment of chronic otitis media. The parent asks the LPN/LVN how to prevent the child from getting ear infections. The LPN/LVN's response should be based on an understanding that the recurrence of otitis media can be decreased by which of the following?

Reworded Question: What will prevent the development of otitis media?  
What causes otitis media?

Strategy: Think about the causes of otitis media.

Needed Info: Otitis media: frequently follows respiratory infection; reduce occurrence by holding child upright for feedings, encourage gentle nose-blowing, teach modified Valsava maneuver (pinch nose, close lips and force air up through eustachian tubes), blow up balloons or chew gum, eliminate tobacco smoke or known allergens.

Category: Planning/Health Promotion and Maintenance

Covering the child's ears while bathing—does not prevent otitis media

Treating upper respiratory infections quickly—CORRECT:  
respiratory fluids are a medium for bacteria; antihistamines used

Administering nose drops at bedtime—not preventative

Isolating the child from other children—too extreme a measure

37. The Answer is 2

A client is calling the suicide prevention hotline to report a personal suicide plan. Which of the following questions should the LPN/LVN ask first?

Reworded Question: What is most important to know about a client who has threatened suicide?

Strategy: "First" indicates priority.

Needed Info: Signs of suicide: symptoms of depression, client gives away possessions, gets finances in order, has a means, makes direct or indirect statements, leaves notes, increase in energy. Predisposing factors: male over age 50, teenagers between 15–19, poor social attachments, clients with previous attempts, clients with auditory hallucinations, overwhelming precipitating events (terminal disease, death or loss of loved one, failure at school, job).

Category: Data Collection/Psychosocial Integrity

“What happened to cause you to want to end your life?”—does not determine immediate need for safety

“Tell me the details of the plan you developed to kill yourself?”—  
CORRECT: lets you prioritize interventions to assure safety

“When did you start to feel as though you wanted to die?”—does not determine immediate need for safety

“Do you want me to prevent you from killing yourself?”—yes/no question, closed

38. The Answer is 2

Prior to the client undergoing a scheduled intravenous pyelogram (IVP), it would be most important for the LPN/LVN to ask which of the following questions?

Reworded Question: What do you need to know before an IVP?

Strategy: Think about each answer and how it relates to IVP.

Needed Info: IVP: radiopaque dye injected into the body and is filtered through the kidneys and excreted by the urinary tract. Visualizes kidneys, ureters, and bladder. Preparation: NPO midnight, cathartics evening before test. Injection of dye causes flushing of face, nausea, salty taste in mouth.

Category: Data Collection/Physiological Integrity/Reduction of Risk Potential

“Do you have any difficulty voiding?”—not most important

“Do you have any allergies to shellfish or iodine?”—CORRECT: anaphylactic reaction; itching, hives, wheezing; treatment: antihistamines, oxygen, cardiopulmonary resuscitation, epinephrine, vasopressor

“Do you have a history of constipation?”—not essential information

“Do you have a history of frequent headaches?”—not most important

39. The Answer is 3

The LPN/LVN is assigned to a newly admitted elderly client in the hospital setting that reports having no living relatives and only friends of similar age. One of the LPN/LVN's most immediate considerations for this client will be to help the RN implement which of the following?

Reworded Question: Given the information provided, what is a priority for this client?

Strategy: Look for the answer that addresses this client's individualized needs/situation.

Needed Info: Client lengths of stay are very short. Likely that this elderly client does not have anyone to assist with care or activities of daily living (ADL) if needed upon discharge. Discharge planning: begins upon admission for all hospitalized clients. Concept map: a conceptual plan that integrates nursing care. Critical pathway: multidisciplinary plan for clinical interventions during hospitalization. Utilization group: classifies clients by disease or injury.

Category: Implementation/Safe and Effective Care Environment/Coordinated Care

A concept map—a plan of care is necessary for every client

A critical pathway—addresses only the acute-care stay

A discharge plan—CORRECT: will provide for the appropriate support this client needs to return to the community or transfer to another level of care

A utilization group—not an important consideration for this client

40. The Answer is 3

A woman delivers a 6 lb 10 oz baby girl. The mother observes the LPN/LVN in the delivery room place drops in her daughter's eyes. The mother asks the LPN/LVN why this was done. Which of the following responses by the LPN/LVN is best?

Reworded Question: Why are eyedrops placed in a newborn's eyes?

Strategy: “Best” indicates that discrimination may be required to answer the question.

Needed Info: Prophylactic care of newborns includes administration of vitamin K to prevent hemorrhage; erythromycin and tetracycline are used for prophylactic eye care.

Category: Implementation/Health Promotion and Maintenance

“The drops constrict your baby’s pupils to prevent injury.”—erythromycin or tetracycline do not cause myosis

“The drops will remove mucus from your baby’s eyes.”—does not remove mucus from baby’s eyes

“The drops will prevent infections that might cause blindness.”—CORRECT: precaution against ophthalmia neonatorum (inflammation of the eyes due to gonorrhea or chlamydia infection)

“The drops will prevent neonatal conjunctivitis.”—conjunctivitis is inflammation of the conjunctiva

41. The Answer is 3

The LPN/LVN is caring for a client admitted for a possible herniated intervertebral disk. The primary health care provider prescribed ibuprofen, propoxyphene hydrochloride, and cyclobenzaprine hydrochloride to be given as needed for pain. Several hours after admission, the client reports . Which of the following actions should the LPN/LVN take first?

Reworded Question: What should you do first?



Strategy: Set priorities. Collect data before implementing.

Needed Info: Herniated disk: knifelike pain aggravated by sneezing, coughing, straining.

Category: Planning/Physiological Integrity/Pharmacological Therapies

Give the client ibuprofen to promptly manage the pain—  
implementation; not first step

Ask the primary health care provider which drug to give first—  
collect data before implementing

Gather more information from the client about the pain—  
CORRECT: collect data; first step in nursing process

Allow the client some time to rest to see if the pain subsides—  
implementation; not first step

42. The Answer is 4

The LPN/LVN is completing a client's preoperative checklist prior to surgery. The nurse obtains the client's vital signs: temperature 97.4° F (36° C), radial pulse rate 84 beats/minute, respiratory rate 16 breaths/minute, and blood pressure 132/74 mm Hg. Which action should the LPN/LVN take first?

Reworded Question: What should you do for a client with normal vital signs?

Strategy: Identify normal vital signs.

Needed Info: Normal vital sign values include blood pressure 139/79 mm Hg, heart rate 60 to 100 beats/minute, and respiratory rate 16 to 20 breaths/minute.

Category: Data Collection/Physiological Integrity/Reduction of Risk Potential

Notify the primary health care provider of client's vital signs—most primary health care providers do not want to be notified about normal values

Obtain orthostatic blood pressures lying and standing—there is no information to support this action

Lower the side rails and place the bed in its lowest position—bed side rails should be raised, not lowered

Record the data on the client's preoperative checklist—CORRECT: the vital signs are normal and should be recorded in the client's medical record

43. The Answer is 3

The LPN/LVN is expecting to see which of the following physiological changes in a client experiencing an episode of acute pain?

Reworded Question: What happens to the vital signs when a client is in pain?

Strategy: Think about the cause of each vital sign change. Is it consistent with pain?

Needed Info: Pain causes increased blood pressure and heart rate, which leads to increased blood flow to the brain and muscles; rapid irregular respirations lead to increased oxygen supply to brain and muscles; increased perspiration removes excessive body heat; increased pupillary diameter leads to increased eye accommodation to light.

Category: Data Collection/Physiological Integrity/Physiological Adaptation

Decreased blood pressure—blood pressure increases to enhance alertness to threats

Decreased heart rate—heart rate increases

Decreased skin temperature—CORRECT: skin cools due to diaphoresis

Decreased respirations—respirations increase

44. The Answer is 4

A client is transferred to a long-term care facility after a stroke. The client has right-sided paralysis and dysphagia. The LPN/LVN observes an unlicensed assistive personnel (UAP) preparing the client to eat lunch. Which of the following situations would require an intervention by the LPN/LVN?

Reworded Question: What option is wrong?

Strategy: This is a negative question. Determine if you are looking for a correct situation or a problematic situation.

Needed Info: Dysphagia: difficulty swallowing. Provide support if necessary for the head, have the client sit upright, feed the client slowly in small amounts, place food on unaffected side of mouth. Maintain upright position for 30–45 minutes after eating. Good oral care after eating.

Category: Evaluation/Physiological Integrity/Reduction of Risk Potential

The client remains in bed in the high Fowler's position—correct positioning, or may sit in chair

The client's head and neck are positioned slightly forward—correct positioning; helps client chew and swallow

The UAP places food in back of the mouth of unaffected side—helps client handle food

The UAP adds tap water to pudding to help the client swallow—  
CORRECT: requires intervention, usually able to better handle soft or semi-soft foods; difficulty with liquids

45. The Answer is 2, 3, and 4

The LPN/LVN's is collecting data and a client's blood pressure is 146/92 mm Hg with labored respirations at a rate of 24 breaths/minute. Bloody drainage appears on the client's IV dressing. The client reports pain in the left hip, depression, and hunger. The LPN/LVN identifies which of these as subjective data? Select all that apply.

Reworded Question: What data have been reported by the client?

Strategy: Look for client-reported data.

Needed Info: Subjective data: client's perceptions. Objective data: information perceptible to the senses (sight, hearing, touch, smell, taste) or measurable data.

Category: Data Collection/Safe and Effective Care  
Environment/Coordinated Care

Blood pressure—measurable objective data

Depression—CORRECT: subjective client-reported data

Hip pain—CORRECT: subjective client-reported data

Hunger—CORRECT: subjective client-reported data

IV drainage—measurable objective data

Respirations—measurable objective data

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## PART 5

# NCLEX-PN<sup>®</sup> EXAM RESOURCES

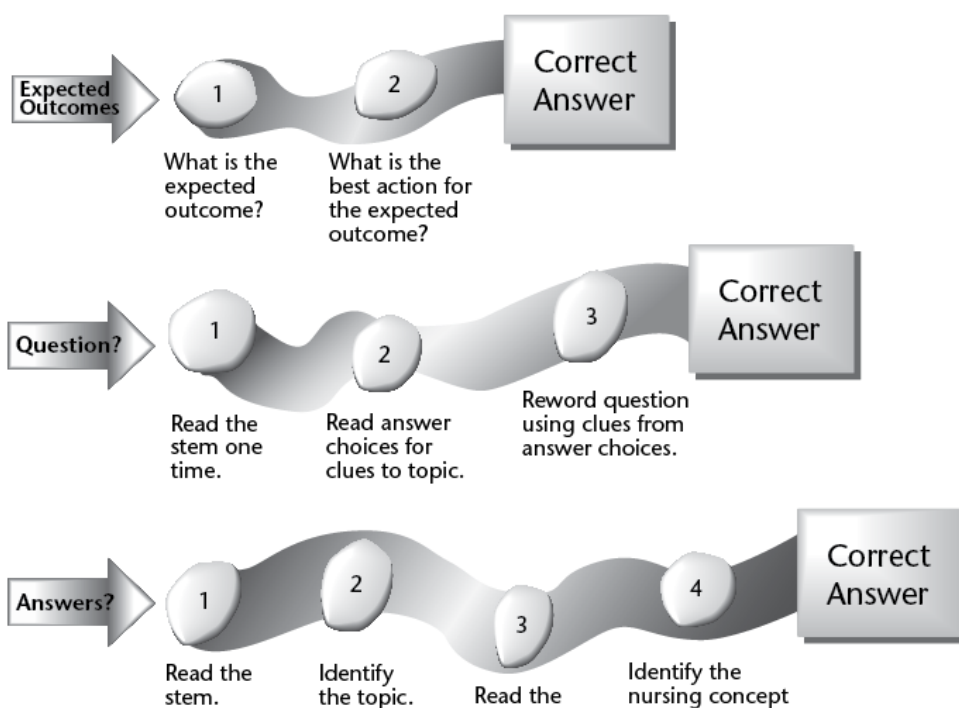
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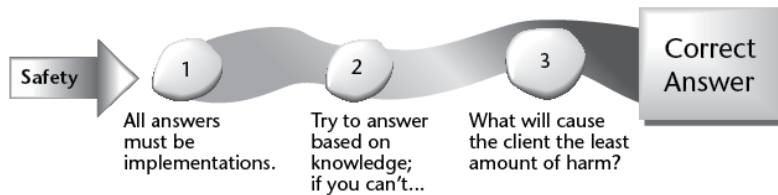
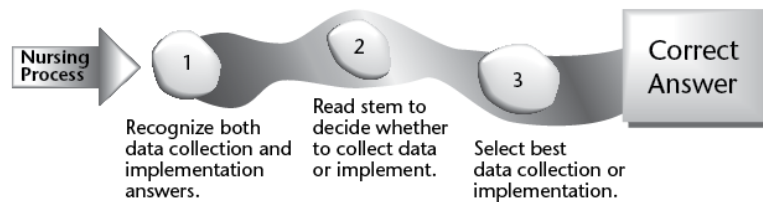
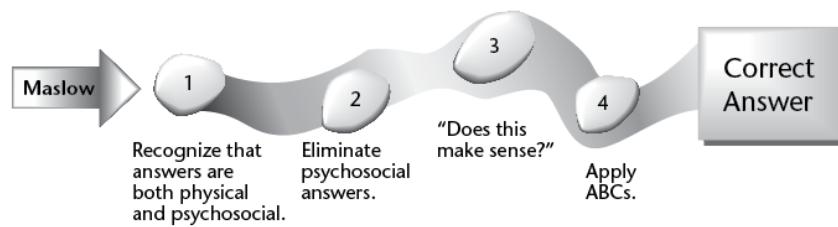
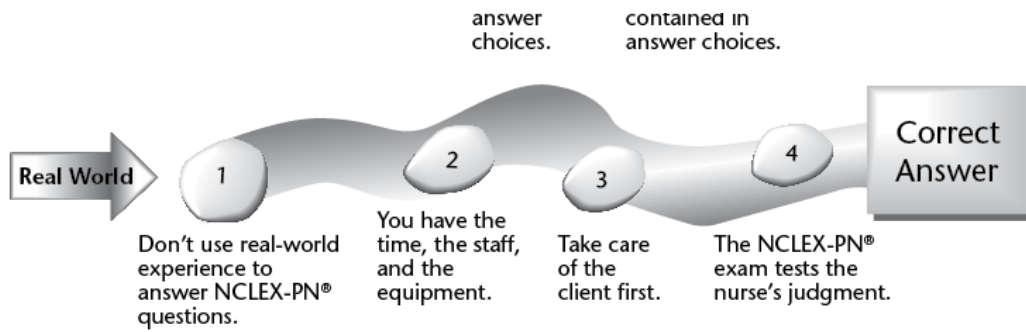
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## APPENDIX A

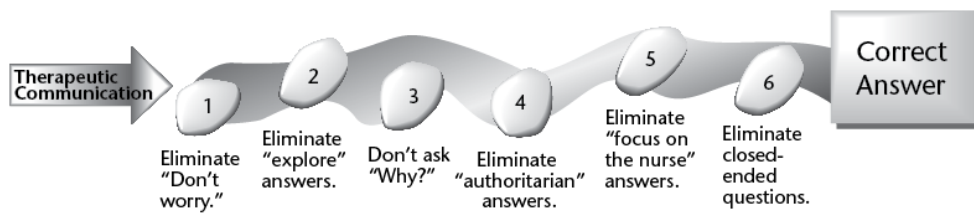
# SUMMARY OF CRITICAL THINKING PATHS

The 9 charts in this appendix illustrate different paths you must choose from in order to correctly answer NCLEX-PN® exam questions. The stepping stones stand for steps that you must follow in order to find the correct answer for that question type. Use the chart to refresh your memory with respect to the various steps for each type of question. Tear out this page and refer to it to practice using this book's strategies when answering practice NCLEX-PN® exam-style questions.











## APPENDIX B

# NURSING TERMINOLOGY

abduction – movement away from the midline

abraded – scraped

acetonuria – acetone in the urine

adduction – movement toward the midline

afebrile – without fever

albuminuria – albumin in the urine

ambulatory – walking

amenorrhea – absence of menstruation

amnesia – loss of or defective memory

ankylosis – stiff joint

anorexia – loss of appetite

anuria – total suppression of urination

apnea – short periods when breathing has ceased

arthritis – inflammation of joint

asphyxia – suffocation

atrophy – wasting

auscultation, auscultate – to listen for sounds

bradycardia – heart rate lower than 60 beats per minute

Cheyne-Stokes respirations – increasing dyspnea with periods of apnea

choluria – bile in the urine

clonic tremor – shaking with intervals of rest

conjunctivitis – inflammation of conjunctiva  
coryza – watery drainage from nose  
cyanotic – bluish in color due to poor oxygenation  
defecation – bowel movement  
dental caries – decay of the teeth  
dentures – false teeth  
diarrhea – excessive or frequent defecation  
diplopia – double vision  
distended – appears swollen  
diuresis – large amount of urine voided  
dorsal recumbent – lying on back, knees flexed and apart  
dysmenorrhea – painful menstruation  
dyspnea – difficulty breathing  
dysrhythmia, arrhythmia – abnormal heartbeat  
dysuria – painful urination  
edematous – puffy, swollen  
emaciated – thin, underweight  
emetic – agent given to produce vomiting  
enuresis – bed-wetting  
epistaxis – nosebleed  
eructation – belching  
erythema – redness  
eupnea – normal breathing  
excoriation – raw surface  
exophthalmos – abnormal protrusion of eyeball  
extension, extend – to straighten  
fatigued – tired  
feigned – pretended  
fetid – foul

fixed – motionless

flaccid – soft, flabby

flatus, flatulence – expulsion of gas from the digestive tract

flexion – bending

flushed – pink or hot

Fowler's position – semierect, knees flexed, head of bed elevated 45–60 degrees

gavage – forced feeding through a tube passed into the stomach

glossy – shiny

glycosuria – glucose in the urine

gustatory – dealing with taste

heliotherapy – using sunlight as a therapeutic agent

hematemesis – blood in vomitus

hematuria – blood in the urine

hemiplegia – paralysis of one side of the body

hemoglobinuria – hemoglobin in the urine

hemoptysis – spitting of blood

horizontal – flat

hydrotherapy – using water as a therapeutic agent

hyperpnea – rapid breathing

hypertonic – concentration greater than body fluids

hypotonic – concentration less than body fluids

infrequent – not often

insomnia – inability to sleep

instillation – pouring into a body cavity

intermittent – starting and stopping, not continuous

intradermal – within or through the skin

intramuscular – within or through the muscle

intraspinal – within or through the spinal canal

intravenous – within or through the vein  
involuntary, incontinent – unable to control bladder or bowels  
isotonic – having the same tonicity or concentration as body fluids  
jackknife position – prone with hips over break in table and feet below level of head  
jaundice – yellow color  
knee-chest position – in face-down position resting on knees and chest  
kyphosis – humpback, concavity of spine  
labored – difficult, requires an effort  
lacerated – torn, ragged edged  
lateral position – on the side, knees flexed  
lithotomy position – on the back, buttocks near edge of table, knees well flexed and separated  
lochia – drainage from the vagina after delivery  
lordosis – sway-back, convexity of spine  
manipulation, manipulate – to handle  
menopause – cessation of menstruation  
menorrhagia – profuse menstruation  
metrorrhagia – variable amount of uterine bleeding occurring frequently but at irregular intervals  
moist – wet  
monoplegia – paralysis of one limb  
mucopurulent – drainage containing mucus and pus  
mydriasis – dilation of pupil  
myopia – nearsightedness  
myosis – contraction of pupil  
nausea – desire to vomit  
necrosis – death of tissue  
nocturia – frequent voiding at night

obese – overweight

objective – able to be documented by other than observation

oliguria – scant urination, less than 400 mL per 24 hours

orthopnea – inability to breathe or difficulty breathing while lying down

palliative – offering temporary relief

pallor – white

palpation, palpate – to feel with hands or fingers

paraplegia – paralysis of legs

paroxysm – spasm or convulsive seizure

paroxysmal – coming in seizures

pediculi – lice

pediculosis – lice infestation

percussion, percuss – to strike

persistent – lasting over a long time

petechia – small rupture of blood vessels

photophobia – sensitive to light

photosensitivity – skin reaction caused by exposure to sunlight

pigmented – containing color

polyuria – excessive voiding of urine

profuse, copious – large amount

projectile – ejected or projected some distance

pronation – turning downward

prone – on abdomen, face turned to one side

prophylactic – preventative

protruding – extending outward

pruritus – itching

ptosis – drooping eyelid

purulent drainage – drainage containing pus

pyrexia – elevated temperature

pyuria – pus in the urine  
radiating – spreading to distant areas  
radiotherapy – using x-ray or radium as a therapeutic agent  
rales, crackles – abnormal breath sounds  
rapid – quick  
rotation – to move in circular pattern  
sanguineous drainage – bloody drainage  
scanty – small in amount  
semi-Fowler's position – semi-erect, head of bed elevated 30–45 degrees  
serous drainage – drainage of lymphatic fluid  
Sims' position – on left side, left arm behind back, left leg slightly flexed, right leg slightly flexed  
sprain – wrenching of a joint  
stertorous – characterized by snoring  
stethoscope – instrument used for auscultation  
strabismus – squinting; misalignment of the eyes  
stuporous – partially unconscious  
subcutaneous – under the skin  
subjective – observed  
sudden onset – started all at once  
superficial – on the surface only  
supination – turning upward  
suppurating – discharging pus  
syncope – fainting  
syndrome – group of symptoms  
tachycardia – fast heartbeat, greater than 100 beats per minute  
tenacious – tough and sticky  
thready – barely perceptible  
tonic tremor – continuous shaking

Trendelenburg position – flat on back with pelvis higher than head, foot of bed elevated 6 inches

tympanic – filled with gas

urticaria – hives or wheals; eruptions on skin or mucous membranes

vertigo – dizziness

vesicle – fluid-filled blister

visual acuity – sharpness of vision

void, micturate – to urinate or pass urine





## APPENDIX C

# COMMON MEDICAL ABBREVIATIONS

ABC – airway, breathing, circulation  
abd. – abdomen  
ABG – arterial blood gas  
ABO – system of classifying blood groups  
ac – before meals  
ACE – angiotensin-converting enzyme  
ACS – acute compartment syndrome  
ACTH – adrenocorticotrophic hormone  
ad lib – freely, as desired  
ADH – antidiuretic hormone  
ADL – activities of daily living  
AFP – alpha-fetoprotein  
AIDS – acquired immunodeficiency syndrome  
AKA – above-the-knee amputation  
ALL – acute lymphocytic leukemia  
ALP – alkaline phosphatase  
ALS – amyotrophic lateral sclerosis  
ALT – alkaline phosphatase (formerly SGPT)  
AMI – antibody-mediated immunity  
AML – acute myelogenous leukemia  
amt. – amount

ANA – antinuclear antibody  
ANS – autonomic nervous system  
AP – anteroposterior  
A&P – anterior and posterior  
APC – atrial premature contraction  
aq. – water  
ARDS – adult respiratory distress syndrome  
ASD – atrial septal defect  
ASHD – atherosclerotic heart disease  
AST – aspartate aminotransferase (formerly SGOT)  
ATP – adenosine triphosphate  
AV – atrioventricular  
BCG – Bacille Calmette-Guerin  
bid – two times a day  
BKA – below-the-knee amputation  
BLS – basic life support  
BMR – basal metabolic rate  
BP – blood pressure  
BPH – benign prostatic hypertrophy  
bpm – beats per minute  
BPR – bathroom privileges  
BSA – body surface area  
BUN – blood urea nitrogen  
C – centigrade, Celsius

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**C** – with  
Ca – calcium  
CA – cancer  
CABG – coronary artery bypass graft

CAD – coronary artery disease  
CAL – chronic airflow limitations  
CAPD – continuous ambulatory peritoneal dialysis  
caps – capsules  
CBC – complete blood count  
CC – chief complaint  
cc – cubic centimeter  
CCU – coronary care unit, critical care unit  
CDC – Centers for Disease Control and Prevention  
CHF – congestive heart failure  
CK – creatine kinase  
Cl – chloride  
CLL – chronic lymphocytic leukemia  
cm – centimeter  
CMV – cytomegalovirus  
CNS – central nervous system  
CO – carbon monoxide, cardiac output  
CO<sub>2</sub> – carbon dioxide  
comp – compound  
cont – continuous  
COPD – chronic obstructive pulmonary disease  
CP – cerebral palsy  
CPAP – continuous positive airway pressure  
CPK – creatine phosphokinase  
CPR – cardiopulmonary resuscitation  
CRP – C-reactive protein  
C&S – culture and sensitivity  
CSF – cerebrospinal fluid  
CT – computerized tomography

CTD – connective tissue disease  
CTS – carpal tunnel syndrome  
cu – cubic  
CVA – cerebrovascular accident or costovertebral angle  
CVC – central venous catheter  
CVP – central venous pressure  
D&C – dilation and curettage  
DC – discontinue  
DCBE – double-contrast barium enema  
DIC – disseminated intravascular coagulation  
DIFF – differential blood count  
dil. – dilute  
DJD – degenerative joint disease  
DKA – diabetic ketoacidosis  
dL, dl – deciliter (100 mL)  
DM – diabetes mellitus  
DNA – deoxyribonucleic acid  
DNR – do not resuscitate  
DO – doctor of osteopathy  
DOE – dyspnea on exertion  
DPT – vaccine for diphtheria, pertussis, tetanus  
Dr. – doctor  
DRE – digital rectal exam  
DVT – deep vein thrombosis  
D/W – dextrose in water  
Dx – diagnosis  
ECF – extracellular fluid  
ECG, EKG – electrocardiogram  
ECT – electroconvulsive therapy

ED – emergency department  
EEG – electroencephalogram  
EMD – electromechanical dissociation  
EMG – electromyography  
ENT – ear, nose, and throat  
ERCP – endoscopic retrograde cholangiopancreatography  
ESR – erythrocyte sedimentation rate  
ESRD – end-stage renal disease  
ET – endotracheal tube  
F – Fahrenheit  
FBD – fibrocystic breast disease  
FBS – fasting blood sugar  
FDA – U.S. Food and Drug Administration  
FFP – fresh frozen plasma  
FHR – fetal heart rate  
FHT – fetal heart tone  
fl – fluid  
FOBT – fecal occult blood test  
4 × 4 – piece of gauze 4 inches by 4 inches; used for dressings  
FSH – follicle-stimulating hormone  
ft. – foot, feet (unit of measure)  
FUO – fever of undetermined origin  
g – gram  
GB – gallbladder  
GCS – Glasgow coma scale  
GFR – glomerular filtration rate  
GH – growth hormone  
GI – gastrointestinal  
gr – grain

gtt – drops  
GU – genitourinary  
GYN – gynecological  
h, hrs – hour, hours  
(H) – hypodermically  
Hb, Hgb – hemoglobin  
HCG – human chorionic gonadotropin  
 $\text{HCO}_3$  – bicarbonate  
Hct – hematocrit  
HD – hemodialysis  
HDL – high-density lipoprotein  
Hg – mercury  
HGH – human growth hormone  
HHNK – hyperglycemia hyperosmolar nonketotic coma  
HIV – human immunodeficiency virus  
HLA – human leukocyte antigen  
 $\text{H}_2\text{O}$  – water  
HR – heart rate  
HSV – herpes simplex virus  
HTN – hypertension  
Hx – history  
Hz – hertz (cycles/second)  
IAPB – intra-aortic balloon pump  
IBBP – intermittent positive pressure breathing  
IBS – irritable bowel syndrome  
ICF – intracellular fluid  
ICP – intracranial pressure  
ICS – intercostal space  
ICU – intensive care unit

I&D – incision and drainage  
IDDM – insulin-dependent diabetes mellitus (type 1)  
IgA – immunoglobulin A  
IM – intramuscular  
I&O – intake and output  
IOP – increased intraocular pressure  
IPG – impedance plethysmogram  
IPPB – intermittent positive-pressure breathing  
IUD – intrauterine device  
IV – intravenous  
IVC – intraventricular catheter  
IVP – intravenous pyelogram or intravenous pyelography  
JRA – juvenile rheumatoid arthritis  
 $K^{+}$  – potassium  
kcal – kilocalorie (food calorie)  
kg – kilogram  
KO, KVO – keep vein open  
KS – Kaposi's sarcoma  
KUB – kidneys, ureters, bladder  
L, l – liter  
lab – laboratory  
lb – pound  
LBBB – left bundle branch block  
LDH – lactate dehydrogenase  
LDL – low-density lipoprotein  
LE – lupus erythematosus  
LH – luteinizing hormone  
liq – liquid  
LLQ – left lower quadrant

LOC – level of consciousness  
LP – lumbar puncture  
LPN – licensed practical nurse  
Lt, lt – left  
LTC – long-term care  
LUQ – left upper quadrant  
LV – left ventricle  
LVN – licensed vocational nurse  
m – minum, meter, micron  
MAO – monoamine oxidase inhibitor  
MAST – military antishock trousers  
mcg – microgram  
MCH – mean corpuscular hemoglobin  
MCV – mean corpuscular volume  
MD – muscular dystrophy, medical doctor  
MDI – metered dose inhaler  
mEq – milliequivalent  
mg – milligram  
Mg – magnesium  
MG – myasthenia gravis  
MI – myocardial infarction  
mL, ml – milliliter  
mm – millimeter  
MMR – vaccine for measles, mumps, rubella  
MRI – magnetic resonance imaging  
MS – multiple sclerosis  
N – nitrogen, normal (strength of solution)  
NIDDM – non-insulin dependent diabetes mellitus (type 2)  
Na<sup>+</sup> – sodium



NaCl – sodium chloride

NANDA – North American Nursing Diagnosis Association

NG – nasogastric

NGT – nasogastric tube

NLN – National League for Nursing

noc – at night

NPO – nothing by mouth (nil per os)

NS – normal saline

NSAID – nonsteroidal anti-inflammatory drug

NSNA – National Student Nurses' Association

NST – non-stress test

O<sub>2</sub> – oxygen

OB-GYN – obstetrics and gynecology

OCT – oxytocin challenge test

OOB – out of bed

OPC – outpatient clinic

OR – operating room

os – by mouth

OSHA – Occupational Safety and Health Administration

OTC – over-the-counter (drug that can be obtained without a prescription)

oz – ounce

P – with

P – pulse, pressure, phosphorus

PA Chest – posterior-anterior chest x-ray

PAC – premature atrial complexes

PaCO<sub>2</sub> – partial pressure of carbon dioxide in arterial blood

PaO<sub>2</sub> – partial pressure of oxygen in arterial blood

PAD – peripheral artery disease

Pap – Papanicolaou smear  
pc – after meals  
PCA – patient-controlled analgesia  
pCO<sub>2</sub> – partial pressure of carbon dioxide  
PCP – Pneumocystis jiroveci pneumonia (formerly Pneumocystitis carinii pneumonia)  
PD – peritoneal dialysis  
PE – pulmonary embolism  
PEEP – positive end-expiratory pressure  
PERRLA – pupils equal, round, react to light and accommodation  
PET – postural emission tomography  
PFT – pulmonary function test  
pH – hydrogen ion concentration  
PICC – peripherally inserted central catheter  
PID – pelvic inflammatory disease  
PKD – polycystic disease  
PKU – phenylketonuria  
PMS – premenstrual syndrome  
PND – paroxysmal nocturnal dyspnea  
PO, po – by mouth  
pO<sub>2</sub> – partial pressure of oxygen  
PPD – positive purified protein derivative (of tuberculin)  
PPE – personal protective equipment  
PPN – partial parenteral nutrition  
PRN, prn – as needed, whenever necessary  
pro time – prothrombin time  
PSA – prostate-specific antigen  
psi – pounds per square inch  
PSP – phenolsulfonphthalein

PT – physical therapy, prothrombin time  
PTCA – percutaneous transluminal coronary angioplasty  
PTH – parathyroid hormone  
PTSD – post-traumatic stress disorder  
PTT – partial thromboplastin time  
PUD – peptic ulcer disease  
PVC – premature ventricular contraction  
q – every  
QA – quality assurance  
qh – every hour  
q 2 h – every two hours  
q 4 h – every four hours  
qid – four times a day  
qs – quantity sufficient  
R – rectal temperature, respirations, roentgen  
RA – rheumatoid arthritis  
RAI – radioactive iodine  
RAIU – radioactive iodine uptake  
RAS – reticular activating system  
RBBB – right bundle branch block  
RBC – red blood cell or red blood count  
RCA – right coronary artery  
RDA – recommended dietary allowance  
resp – respirations  
RF – rheumatic fever, rheumatoid factor  
Rh – antigen on blood cell indicated by + or –  
RIND – reversible ischemic neurologic deficit  
RLQ – right lower quadrant  
RN – registered nurse

RNA – ribonucleic acid

R/O, r/o – rule out, to exclude

ROM – range of motion (of joint)

Rt, rt – right

RUQ – right upper quadrant

Rx – prescription

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**S** – without

S., Sig. – (Signa) to write on label

SA – sinoatrial node

SaO<sub>2</sub> – systemic arterial oxygen saturation (%)

sat sol – saturated solution

SBE – subacute bacterial endocarditis

SDA – same-day admission

SDS – same-day surgery

S/E – side effects

sed rate – sedimentation rate

SGOT – serum glutamic-oxaloacetic transaminase (see AST)

SGPT – serum glutamic-pyruvic transaminase (see ALT)

SI – International System of Units

SIADH – syndrome of inappropriate antidiuretic hormone

SIDS – sudden infant death syndrome

SL – sublingual

SLE – systemic lupus erythematosus

SMBG – self-monitoring blood glucose

SMR – submucous resection

SOB – shortness of breath

sol – solution

sp gr – specific gravity

spec. – specimen

ss – one half

SS – soapsuds

S/S, s/s – signs and symptoms

SSKI – saturated solution of potassium iodide

stat – immediately

STD – sexually transmitted disease

subcut, SubQ – subcutaneous

sx – symptoms

Syr. – syrup

T – temperature, thoracic (followed by the number designating specific thoracic vertebra)

T&A – tonsillectomy and adenoidectomy

tabs – tablets

TB – tuberculosis

T&C – type and crossmatch

TED – antiembolitic stockings

temp – temperature

TENS – transcutaneous electrical nerve stimulation

TIA – transient ischemic attack

TIBC – total iron binding capacity

tid – three times a day

tinct, tr. – tincture

TLC – total lymphocyte count

TMJ – temporomandibular joint

TPA, t-pa – tissue plasminogen activator

TPN – total parenteral nutrition

TPR – temperature, pulse, respiration

TQM – total quality management

TSE – testicular self-examination  
TSH – thyroid-stimulating hormone  
tsp. – teaspoon  
TSS – toxic shock syndrome  
TURP – transurethral prostatectomy  
UA – urinalysis  
um – unit of measurement  
ung – ointment  
URI – upper respiratory tract infection  
UTI – urinary tract infection  
VAD – venous access device  
VDRL – Venereal Disease Research Laboratory (test for syphilis)  
VF, Vfib – ventricular fibrillation  
VPC – ventricular premature complexes  
VS, vs – vital signs  
VSD – ventricular septal defect  
VT – ventricular tachycardia  
WBC – white blood cell or white blood count  
WHO – World Health Organization  
WNL – within normal limits  
wt – weight  
X PO – 10 grains per orem

## APPENDIX D

# STATE BOARDS OF NURSING

Requirements regarding examination/re-examination, licensure fees, temporary permits, license renewal, continuing education unit (CEU) requirements, etc., vary by state. Your state board of nursing is the best source for up-to-date information on these requirements. The following list provides the website URL for each state licensing board in the United States.

### Alabama

Board of Nursing

Website: [www.abn.alabama.gov](http://www.abn.alabama.gov)

### Alaska

Board of Nursing

Website:

<https://www.commerce.alaska.gov/web/cbpl/ProfessionalLicensing/BoardofNursing/ApplicantInformation/RNLPNApplications.aspx>

## Arizona

State Board of Nursing

Website: [www.azbn.gov](http://www.azbn.gov)

## Arkansas

State Board of Nursing

Website: [www.arsbn.arkansas.gov](http://www.arsbn.arkansas.gov)

## California

Board of Vocational Nursing and Psychiatric Technicians

Website: [www.bvnpt.ca.gov](http://www.bvnpt.ca.gov)

## Colorado

Board of Nursing

Website: <https://www.colorado.gov/dora/Nursing>

## Connecticut

Board of Examiners for Nursing

Website: <http://www.ct.gov/dph/cwp/view.asp?a=3143&q=388910>

## Delaware

Board of Nursing

Website: <http://dpr.delaware.gov/boards/nursing>



## District of Columbia

Board of Nursing

Website: <http://doh.dc.gov/node/149382>

## Florida

Board of Nursing

Website: <http://floridasnursing.gov/>

## Georgia

Board of Nursing

Website: <http://sos.ga.gov/index.php/licensing/plb/45>

## Hawaii

Board of Nursing

Website: <http://cca.hawaii.gov/pvl/boards/nursing/>

## Idaho

Board of Nursing

Website: <http://ibn.idaho.gov>

## Illinois

Center for Nursing

Website: <http://nursing.illinois.gov/>

Indiana

State Board of Nursing

Website: [www.in.gov/pla/nursing.htm](http://www.in.gov/pla/nursing.htm)

Iowa

Board of Nursing

Website: <https://nursing.iowa.gov>

Kansas

State Board of Nursing

Website: [www.ksbn.org](http://www.ksbn.org)

Kentucky

Board of Nursing

Website: [www.kbn.ky.gov](http://www.kbn.ky.gov)

Louisiana

State Board of Nursing

Website: [www.lsbns.state.la.us](http://www.lsbns.state.la.us)

Maine

State Board of Nursing

Website: [www.maine.gov/boardofnursing](http://www.maine.gov/boardofnursing)

## Maryland

### Board of Nursing

Website: <http://mbon.maryland.gov/Pages/default.aspx>

## Massachusetts

### Board of Registration in Nursing

Website:

<http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/dhpl/nursing/>

## Michigan

### Board of Nursing

Website: [http://www.michigan.gov/lara/0,4601,7-154-72600\\_72603\\_27529\\_27542-59003--,00.html](http://www.michigan.gov/lara/0,4601,7-154-72600_72603_27529_27542-59003--,00.html)

## Minnesota

### Board of Nursing

Website: <http://mn.gov/boards/nursing/>

## Mississippi

### Board of Nursing

Website: <http://www.msbn.ms.gov/Pages/Home.aspx>

## Missouri

Board of Nursing

Website: [www.pr.mo.gov/nursing.asp](http://www.pr.mo.gov/nursing.asp)

Montana

Board of Nursing

Website:

[http://b.bsd.dli.mt.gov/license/bsd\\_boards/nur\\_board/board\\_page.asp](http://b.bsd.dli.mt.gov/license/bsd_boards/nur_board/board_page.asp)

Nebraska

Board of Nursing

Website: <http://dhhs.ne.gov/publichealth/Pages/crlnursinghome.aspx>

Nevada

State Board of Nursing

Website: [www.nevadanursingboard.org](http://www.nevadanursingboard.org)

New Hampshire

Board of Nursing

Website: <http://www.nh.gov/nursing/>

New Jersey

Board of Nursing

Website: [http://njpublicsafety.com/ca/nursing/nur\\_applications.htm](http://njpublicsafety.com/ca/nursing/nur_applications.htm)

New Mexico

Board of Nursing

Website: [nmbon.sks.com](http://nmbon.sks.com)

New York

Office of the Professions, Nursing Unit

Website: [www.op.nysed.gov/prof/nurse](http://www.op.nysed.gov/prof/nurse)

North Carolina

Board of Nursing

Website: [www.ncbon.com](http://www.ncbon.com)

North Dakota

Board of Nursing

Website: [www.ndbon.org](http://www.ndbon.org)

Ohio

Board of Nursing

Website: [www.nursing.ohio.gov](http://www.nursing.ohio.gov)

Oklahoma

Board of Nursing

Website: <http://nursing.ok.gov/>

## Oregon

State Board of Nursing

Website: <http://www.oregon.gov/OSBN/pages/index.aspx>

## Pennsylvania

State Board of Nursing

Website:

<http://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Nursing/Pages/default.aspx#.VfdHC02FOrY>

## Rhode Island

Nurse Registration and Nursing Education Board

Website: [www.health.ri.gov/nursing](http://www.health.ri.gov/nursing)

## South Carolina

Board of Nursing

Website: [www.llr.state.sc.us/pol/nursing](http://www.llr.state.sc.us/pol/nursing)

## South Dakota

Board of Nursing

Website: <http://doh.sd.gov/boards/nursing/>

## Tennessee

Board of Nursing

Website: <http://tn.gov/health/article/nursing-about>

Texas

Board of Nursing

Website: [www.bon.state.tx.us](http://www.bon.state.tx.us)

Utah

Division of Occupational and Professional Licensing, Nursing

Website: [www.dopl.utah.gov/licensing/nursing.html](http://www.dopl.utah.gov/licensing/nursing.html)

Vermont

Board of Nursing

Website: <https://www.sec.state.vt.us/professional-regulation/list-of-professions/nursing.aspx>

Virginia

Board of Nursing

Website: [www.dhp.virginia.gov/nursing](http://www.dhp.virginia.gov/nursing)

Washington

State Nursing Commission

Website:

<http://www.doh.wa.gov/LicensesPermitsandCertificates/NursingCommissi>

on

West Virginia

Board of Examiners for Licensed Practical Nurses

Website: <http://www.lpnboard.state.wv.us/>

Wisconsin

Board of Nursing

Website: <http://dsps.wi.gov/Boards-Councils/Board-Pages/Board-of-Nursing-Main-Page/>

Wyoming

State Board of Nursing

Website: <https://nursing-online.state.wy.us>